SOCCEP Q/A
Monday, April 6

Time	Session Details	Question	Answer
9:00 – 10:00 AM	**Andrew Meagher, OD, FAAO** **Glaucoma Pharm & 2nd Line of Therapy**	Can you comment on the differences in prostaglandins and a side effect not mentioned, orbital "hollowing".	Hey, unfortunately I cant comment personally on the orbital hollowing (lipodystrophy) patients may experience from differing PGAs but did find an insightful article that lists some reports in the literature. One of the reports mentions 0.03% Lumigan as the culprit which fortunately for us isn't utilized anymore given the 0.01% formulation works just as well with less side effects. These cosmetic side effects overall are things to discuss with each patient and if they are of great concern we fortunately have other options. All in all the biggest take-home message is that unilateral treatment with a PGA accentuates the cosmetic changes seen and it's my recommendation to treat bilaterally to mask the changes and make them appear less obvious—hope that helps! link: https://www.reviewofophthalmology.com/article/pap-new-concerns-for-prostaglandin-use
		How do you know for sure that the CME and uveitis in pts. using an alpha agonist is not just co-morbidity and not from the med.	There truly is no tell-tale sign to discern comorbidity other than the timing with the use of the medication and other clinical signs that relate to each disease, ie: brimonidine allergy is going to always present with a follicular and/or mixed follicular/papillary conjunctival reaction, and in one of my cases the patient was only using brimonidine in one eye and that happened to be the eye with the allergic and uveitic response. Another case I had we did run a blood panel and it came back negative, paired with the discontinuation of the brimonidine alleviated the uveitis. In the case of CME you have to look at the other factors that can cause CME - ie: poorly controlled diabetes, post-op cataract surgery being the top 2 that come to mind, and determine if they are playing a role in that patient. You may not always be able to tell cut and dry but if it's that much of a concern then d/cing

			the brimonidine would be a logical next step to see if the CME improves—hope that helps!
		Is the CME with Alpha2Agnoists more or less common than with PGAs?	Since both medications have vasoactive properties they both have the propensity but if far more common in PGAs. When epinephrine and dipivefrin were more commonly use this was a greater issue, iopodine has a higher propensity than brimonidine, but iopidine/apraclonidine is not recommended to use long term bc of the extensive side effects - one being allergic/follicular conjunctivitis which occurs at a faster rate than would brimonidine—hope that helps!
		why rhopressa QAM and not QHS?	Great question, and truly rhopressa can be taken at any time of day as long as its taken the *same time* each day. If there is no frank hyperemia and the patient is on multiple glaucoma meds (which most are if we are resorting to rhopressa) it becomes an easier schedule to say do AM: rhopressa + cosopt, PM: travatan z + cosopt, rather than 1 med in the AM and 3 meds in the evening, as long as you educate your patient properly on how often the meds need to be taken then they can cater it to the way that best fits their schedule—side note: some patients schedule works better to take their prostaglandin in the AM and I've seen improved efficacy simply bc compliance improved. Also rhopressa needs to be refrigerated and it is sometimes more convenient to take it in the morning due to its location.—hope that helps!
		Dr. Meagher, what are your go to resources for glaucoma medications, management, and treatment?	I tend to use Yanoff & Duker's Ophthalmology textbook for the majority of foundational information. https://eyewire.news is a great site for up and coming info regarding all things optometry as well. In some cases I will take a look at Eyewiki and utilize the sources at the bottom to get further detail. Working at a university I can obtain articles that aren't free rather easily, I would look into seeing if your school has a similar method for

			students and/or alum (unless you are from PCO?—Sorry the questions don't give names)—Anyways I hope that is helpful
		If one field shows progression for the first time, do you have them come back and repeat a field before starting them on an additional drop? Or do you start the additional drop right away?	I like concrete evidence before subjecting a patient to what I consider a life time of medical treatment. It should be an intelligent and well thought out decision and not a knee-jerk reaction for fear of being sued. The field defect should always match the OCT and optic nerve assessment—if it doesn't then you need to consult with neuro for possible non-glaucomatous etiologies. It's somewhat advantageous that primary open angle glaucoma is a slow acting disease (the same cant be said for acute cases ie: NVG, angle closure) because you have the time in between your quarterly (3 month) visits to obtain new testing and the decision to treat or add medications always comes down for me to a worsening field or a reliable and repeatable field—and between all that not really lose any ground to the glaucoma—and is one reason why standard of care is to monitor in 3 month intervals. Given all of that I try my best to space out fields in most cases by at least 3 months unless it's a truly fragile case then I will repeat sooner and monitor more closely. Some other tips I might add is if you have a reliable OD field but a not so reliable OS field then next field you should start with OS so that you'll at least have a reliable field for each in within a short time frame.—Hope that makes sense and is helpful!
		Could we get a copy of the powerpoint? A LOT of great information.	Glad you found it useful! All facilitators have been given access to share with their corresponding schools, I would reach out to a facilitator at your college for access.
		Can you please show slide that lists the order of prefered glaucoma drugs ?	I believe you can obtain access via a facilitator at your respective college for the slides, but in regards to order of my preferred drugs I'm happy to share. Each case is different but in ideal situations (which is almost never the

			case lol) I'd start out with a prostaglandin ideally Travatan Z or Lumigan which have similar efficacy and really have no factors to alter my decision making—I will say however Allergan has been more supportive, resourceful and otherwise present more than Alcon has and given we have more resources for our patients to obtain their medication I have been using Lumigan more frequently as a first line. After that, if a patient has phenomenal insurance then Rhopressa is my next choice-its once daily administered and I have over 80 patients taking it and it works, but the hyperemia you can get from it is awful and needs to be explained to patients. In a practical sense my next preferred drop is a CAI, either dorzolamide or Azopt—just depends on insurance. BUT if a patient is normotensive I'm more apt to go brimonidine/Alphagan as my second choice for it's possible neuroprotection (has not been proved through human studies but there is a lot of support in animal models) - stay tuned as I may present a glaucoma mythbusters in the near future on questions like this!—Hope this was helpful for you
10:00 – 11:00 am	**Barbara Caffery, OD, PhD, FAAO** **Can contact lenses solve the problems of corneal disease from multiple sources?**	Hello, thank you for the great talk! Question, do you know why the sclerals were coating up within 2 hours? Is this seen more often in OSD patients?	I wish I knew why they were coating. This is a major problem with dry eye patients. My most common experience is with GVHD. It must be the composition of the tear film. You have likely seen patients who coat up soft lenses are their RGPs. I always review care and handling, encourage the rubbing of wettable conditioning solutions like Boston conditioner prior to insertion and the real need to remove, clean, recondition and rewet during the day. It is a BIG problem.
11:00 – 12:00 pm	**Bryce St. Clair, OD** **No Wiggle Room: Clinical Decision Making with Chorioretinal Folds**	What dose do you use for steroid and cycloplegics in hypotonous eyes?	Cycloplegics initiated are cyclopentolate or atropine 1-2% dosed BID. Steroids initiated are usually prednisolone acetate or Durezol

			because of their effectivity in increasing IOP. They are dosed Q1-2hrs, respectively.
1:00 – 2:00 pm	**Stephanie Woo, OD, FAAO** **What to do When No Contact Lenses Fit on a Complex Cornea**	How did you count the endothelial cells?	Using a specular microscope, the instrument will give you the endothelial cell count, cell variability, cell size, etc
		Could we please have an expanded discussion on elevation vs axial maps?	Topographers will give you different maps. Axial maps give you the curvature of the different areas of the cornea, while elevation maps tell you areas that are tall vs short. You can have a very tall elevated area of the cornea that is very flat and conversely a very short area of the cornea that is very steep. Sometimes the maps can be misleading if you only look at one.
		Which soft lenses are made for transplants?	Contact different laboratory manufacturers because they all have different fitting sets for transplants
		Couldn't you notch the scleral lens in instances of blebs?	Yes you can notch, but the notch needs to be perfectly in place or else you risk erosion. I prefer vaulting over the bleb to help sheild it.
		Is Corneal GP lens bearing over the graft-host margin (along with sutures present) something we should worry about with our corneal transplant patients?	Sometimes it is. This is why you must follow up with them quite frequently to make sure the graft is staying healthy
		can you make a notch around the bleb with sclerals?	Yes many scleral lens companies are able to notch
		Could you have considered using a BostonSight PROSE device to help fit over the bleb?	Yes the PROSE is a scleral lens similar to the EyePrint PRO. The PROSE uses a CAD CAM system to create a lens while the Eyeprint uses the impression taken of the eye.
		What effect , if any, does this scleral lens have on IOP?	This is a heavily researched topic and we don't know at this point.
		Was there an indication to fenestrate this lens?	Fenestration has started to emerge as helpful for certain patients. However, with her transplant being so irregularly shaped, I feared a fenestration would cause too much of an air bubble and she would have issues of dislodgement.

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2:00 – 3:00 pm	**Richard Mangan, OD, FAAO** **Autologous Serum - From the Inside Out.**	You mentioned that instilling an anasthetic gives a false low reading on Shirmer. I've also learned that not using an anasthetic give a false high due to reflex tearing. I've learned that it' good to run both tests, both give useful information. What makes you prefer not using anasthetic?	I have no problem with someone doing both. With that said, a 1mm shirmer test without an anesthetic is considered diagnostic for SS. If you get such a poor response without an anesthetic, is repeating the test with an anesthetic going to really give you more information?
		How do you address a patient's quality of life concerns when they need drops every 2 hours and the drops need to be refrigerated?	You have to keep in mind that Serum tears are often prescribed after patients have tried just about every other commercial product out there. These patients are often on MMT (maximum medical therapy). They often say “I will try anything” if it will help. Many patients that go on ASEDs are able to reduce or eliminate other commercial products, so the dosing isn’t too much of a concern. Some are able to take a bottle or two to their office and keep them in the freezer there. For long trips with questionable freezer options, patients can simply go back on preservative-free tears until they return home.
		So when you’re getting 20 to 50 percent serum, is that something that you’re requesting from the lab or are you diluting it in the office?	I order what percentage serum I want, and the compounding pharmacy formulates it.
		Can you go over how you selected 20% serum level?	It mainly has to do with the serum levels of TGB-1. TGB-1 is a growth factor that is pro-inflammatory if present in too high of a percentage. The TGB-1 levels in serum are 5x the normal amounts when compared to tears. Therefore, a 20% solution puts those levels at a normal level for eye drops.
		what are your thoughts on recent studies regarding finger-prick autologous blood for persistent epi defects?	Disclaimer: I have no experience with this. With that said, I have enough problems with patients being able to administer eye drops themselves, much less do this process. However, for the right patient, it may have some merit. Some are studying breast milk for wound healing and sterilization in third world countries. Who knows where we will be 10 years from now.

		Does insurance cover the cost of these drops?	No
		Albumin vs. serum tears??	Albumin is a nice alternative for those patients with contraindications for autologous serum. It can be ordered through a compounding pharmacy and the cost can be better compared to ASEDS. With said, ASED's more naturally mimics our own natural tears.
		Would you mind telling us what you charge for this service? Are the drops themselves 400 dollars for 3 months?	At the university, it cost $250.00 for a 3 month supply of tears. This includes shipping of the formulated tears to their home. We also do not charge for the blood draw. So the fee is all-inclusive.
		Did you hire staff with specific skills for this part of your practice?	When I formulated ASEDs in private practice, I had a licensed phlebotomist doing the draws and formulating the tears. With the increased regulations on pharmaceutical compounding these days, I would recommend you outsource this. So you wouldn't need to hire anyone specially trained. Don't forget the company Vital Tears as an option.
		When is PRP indicated vs. autologous serum?	PRP might be indicated for severe cases that have not responded to 50% ASEDs + other therapies. If the cost were the same as ASEDS, then we would use it more, but the cost is significantly higher due to the more complicated process.
		Do you leave the, on their current drops when adding serum?	Most of the time, patients can go off products like Restasis and only use PFATs if they run out of their serum or are traveling. Each patient is different, but most of the time, patients are able to reduce or eliminate a number of the topical medication.

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3:00 – 4:00 pm	**Karin Lypka, OD, FAAO** **Optical Coherence Tomography Angiography: Review and Use in Idiopathic Foveal Hypoplasia and its Correlation to Visual Acuity**	No questions	
4:00 – 5:00 pm	**Jeff Walline, OD, PhD, FAAO** **Myopia Control**	For severe progression and/or high myopia, would you ever consider combining different treatment options?	Two studies have been conducted with orthokeratology and low concentration atropine. Both reported additional benefits with the combination therapy, but a critical evaluation of one paper indicates that may not be true. In short, there is still controversy about whether combination therapy provides better myopia control than monotherapy.
		If you started a patient on myopia control at age 8, would you continue the treatment up to age 15-16? or would you discontinue after a couple years and then re-evaluate?	There is no evidence to indicate the best practice, but anecdotally, I would maintain the child on myopia control treatment until age 15 or 16, and if no longer progressing, then consider stopping myopia control treatment. Of course, if the patient experience any meaningful side effects, I would consider stopping earlier.
		Great presentation	Thank you!
		Have you found the same success with atropine 0.05% vs. 0.01%?	In a study, 0.05% was found to provide better myopia control without additional side effects. It also provided better control of eye growth, so I recommend it as the first line treatment.
5:00 – 6:00 pm	**Joe Shovlin, OD, FAAO** **Flashing Lights: Land Mines & Peril Ahead**	What is a prism flash?	This is how the patient described the entoptic phenomenon; the photopsia that took on the form of a prism shape.
		Can we have Dr. Shovlin tell us his email again at the end of the presentation for those of us who missed it at the beginning?	jpshovlin@gmail.com

SOCCEP Q/A
Tuesday, April 7

Time	Session Details	Question	Answer
9:00 – 10:00 AM	**Alice McCaslin, OD, MS, FAAO** **Management of Traumatic Hyphema with Sickle Cell**	Why did you start with diamox and not methazolamide 1st?	Acetazolamide has been shown to be more effective in lowering IOP than Methazolamide, and the patient needed a significant drop in IOP – though for cases where you're suspicious that the patient may have sickle cell trait or disease, it would certainly be a better idea to start with Methazolamide rather than Acetazolamide.
		Why did you chose Cyclopentolate for management rather then Atropine or Homatropine?	To be honest, it was out of habit – especially when prescribing for a patient to get drops at a pharmacy, it's very difficult to get Homatropine due to shortages/backorders. Atropine would probably have the best/easiest dosing frequency (once a day) but has also recently been backordered. So generally I prescribe Cyclopentolate for cyclopegia because it is more likely to be available at a pharmacy.
10:00 – 11:00 am	**Lexi Malkin, OD, FAAO** **Low Vision Management of Pediatric Optic Neuropathies**	No questions	
11:00 – 12:00 pm	**Jeff Anshel, OD, FAAO** **Nutrition for Vision: Nutrition Science for Ocular Health**	How do you view the results of the DREAM study?	This can be a long, involved issue but in hitting the "high points", I'm generally not a fan of JUST using fish oil to treat dry eye. I didn't like the placebo (olive oil) because there are benefits there and the fact that they allowed them to continue their existing treatments could have skewed the results. Additionally, a follow-up study confirmed the original results that fish oil had no significant effects for dry eye. I prefer a more "robust" approach: SOME fish oil but also GLA, antioxidants, vitamins A and D, and the other molecules that I mentioned.

SOCCEP Q/A
Tuesday, April 7

1:00 – 2:00 pm	**Andrew Bodwell, OD, FAAO** **Cerebellar Insults: A Case Series**	Can you explain again what you said about hydrocephalus and definition please.	Sure thing. Hydrocephalus is the increase in cerebrospinal fluid in the ventricles and spaces surrounding the brain that will show enlargement of the ventricles on imaging. Most forms are due to obstructed CSF flow in the ventricles. This is very dangerous because it puts pressure on the brain and needs to be addressed with shunting.
		Hello! Can we get a copy of this ppt?	I believe the Academy is addressing this.
		Hi! Is it possible for me to receive the dropbox lik for these slides?	See above
		May I have copies of slides please?	See above
2:00 – 3:00 pm	**Janis Winters, OD, FAAO** **Low Vision Rehabilitation: Going Beyond Traditional Magnification Devices**	Thank you Dr. Winters! Absolutely going to be looking out for the Sunu device at the next meeting so cool.	
3:00 – 4:00 pm	**Mark Wilkinson, OD, FAAO** **Driving & Vision Loss: A Case Series**	Would you/do you report people who have told you they cheated on their drivers exam?	I advise that person that they do not meet the visual requirements for driving in their state. If a discretionary review option is possible, I offer to advocate for them to get a behind the wheel test, so they can demonstrate that despite their reduced visual acuity and/or visual field, they can still safely operate a motor vehicle. If discretionary review is possible in their state, this is the option to maintain a valid driver's license.
		How do you go about taking someones license away due to their vision?	We cannot physically take away someone's keys or driving privileges. First, I will tell the person they no longer meet the vision requirements for driving in their state. If discretionary review is possible, we discuss that option. If they are unwilling to pursue a discretionary review, I advised them they should retire from all driving immediately. I remind them that I am documenting in their chart that I have told them they are no

			longer visually qualified to drive. I discuss with them that they will have personal liability if they are involved in an accident and someone checks on their vision. Finally, if the person is unwilling to stop driving, I tell them I am going to report them to the Department of Transportation/Department of Motor Vehicles in their state. The state DOT/DMV will then call the person in for an evaluation, determine that the person is no longer visually qualified to drive and they will take their license away from them. You may think this is not what you want to do, but you do not want to be sued, for not having this conversation, when your patient kill someone when driving. As I said during my presentation, I am currently involved in a lawsuit where this happened. It is a tragic situation for everyone, especially for the eye care providers who advised the driver he was OK to drive, despite not being visually qualified to do so in his state.
		In case 7, I know he was not safe to drive, but what about his job? Did he have to retire from his job as a judge as well?	The reason this judge's problem came to attention was it was discovered that he was not able to read and process the paperwork he was being given to read in the court room, because of his Visual Variant of Alzheimer's (VVA) disease, which affects higher order visual processing skills. Because of these higher order processing problems, it was determined he could no longer work as a judge and all of his cases for the previous 3 years had to be reviewed. In this case, as is the case with most everyone with VVA, working was the least of his problems.
		Can I please get a change to review the slide that is titled Duty to Drive please?	It is actually, Duty to Warn. Here is the slide information. Driving Legalities Duty to Warn • Legal rational is to provide a means of protecting the patient from an unreasonable risk of

			harm. • Failure to warn patients of conditions that create a risk of injury will be upheld as a cause of action against eye care providers when it can be shown that the failure to warn is the proximate cause of an injury. • The patient can argue that they had insufficient warning of their impairment, and because of their impairment, their operation of a motor vehicle or other machinery resulted in an injury. • Patients whose vision no longer legally qualifies them to operate a motor vehicle should be warned not to drive and a notation to this effect should be entered into the patient's record. Classe, J. G. (1986) Clinicolegal Aspects of Practice. Southern Journal of Optometry IV, I January
4:00 – 5:00 pm	**Ryan S Vida, OD, FAAO** **Vision Correction Options for the Extreme Rx: FYI on ICLs**	How does one decide between recommending ICL vs clear lens extraction for someone with extreme Rx?	The short answer is that for a myopic patient, the answer is always ICL. The reason for this is the high risk of retinal detachment in a highly myopic eye (i.e. long axial length). The long answer is that most surgeons will choose an ICL up to the age of 60. However, that is not always the case. That brings up a lot of hot topic points when it comes to clear lens extraction so I think it is best to leave it at...ICL is safer than CLE in almost every imaginable case.
		What is the reason for the LPI?	The LPI is made to ensure proper aqueous flow.
		Is there any risk of the ICL dislocating with trauma?	There is always a risk to dislocating a foreign body inside the eye. This is one of the reasons that ICL should not be recommended to patients that are involved in heavy contact sports (i.e. football or boxing). The ICL may move around even without being dislocated

			and increase the chance for early cataract formation. True dislocation is also a possibility, but this would be extremely rare. I saw one case in my career. A spring loaded hinge from a garage door caused a handle to unwind at high speed and made contact directly with the orbit. Sadly for the patient, the ICL moving was the least of her ocular worries. After the retinal and orbital trauma was dealt with, she was sent back to us to manage the ICL. The lens had partially come through the pupil and was in the anterior chamber. The ICL was repositioned without any further complications.
		Hello, several questions: Is there protocol for managing a growing cataract in a patient who has undergone ICL surgery? Is the ICL replaced with PCIOL in cataract extraction? Or is the natural lens removed and ICL changed to the appropriate power? Thank you!	• This varies widely but the general feeling is that because the cataract progression varies so widely that it is probably best just to leave the lens in and see what happens. Most of these patients will progress extremly slowly or may get a little peripheral lens change that never advances. Removing the lens may further increase the chance of progression. • In cataract surgery, the ICL is simply taken out and a normal IOL of the surgeons choosing (as in any standard cataract surgery) is put in.
5:00 – 6:00 pm	**Mika Moy, OD, FAAO** **Grand Rounds in Anterior Segment**	How long has the pt been on OCP?	The patient had been on oral contraceptive pills longstanding
		Due to her systemic health and her BC use, why did you prescribe an antibiotic like doxy to this particular pt? Or is there not an interaction between BC and low dose doxy?	There is a theoretical interaction of birth control and doxycycline. However, this has been called into question many, many times. Here's a good general article. https://www.drugs.com/article/antibiotics-and-birth-control.html So, we could surmise that if antibiotic doses don't interfere, then low dose anti-inflammatory doses would have even less chance.

		What method do you prescribe for warm compresses?	I ascribe to Donald Korb's research showing that wet heat and 10 minutes time is critical for an effective warm compress. However, from my perspective, I understand that a less-than-perfect warm compress is still better than no warm compress. So, I often recommend masks which can be heated in a microwave and retain their heat. It's a dry heat, though. I do emphasize 10 minutes in either case. And, in my part of the country, it seems many people don't have microwaves!? So, in that case, it's wet heat.
		What are your thoughts on hypochlorous acid treatment for patients with ocular rosacea?	I like hypochlorous acid and find it very effective for many applications. One of my favorites right now is cleaning eyelash extensions. I think that some versions are cost prohibitive for my patient population. Therefore, I tend to prescribe the less expensive versions and anecdotally I find them just as efficacious. In this patient's case, I wanted to make sure I got immediate compliance and I knew prescribing a medicine she could easily get from the pharmacy in my building meant she would be compliant. For long-term management, hypochlorous acid is a great choice.

SOCCEP Q/A
Wednesday, April 8

Time	Session Details	Question	Answer
9:00 – 10:00 AM	**Janis Winters, OD, FAAO** **Vision Rehabilitation: History Testing Devices**	No Questions	
10:00 – 11:00 am	**John Gialousakis, OD, FAAO** **Keratoconus: When Specialty Contact Lenses Work & Don't Work**	when are you referring for crosslinking eval?	For new KC patients, I check for progression over a period of 6 months. At the first exam, I'll complete baseline topography, acuity, refraction, cornea eval, etc., and then repeat in 6 months. If there is progression and/or changes, referral for CXL!
		Would you have referred this px early for X-linking, or was he too advanced OD?	He was too advanced in the right eye with scarring. His left eye can be considered (and it was). You could monitor for progression (see previous answer), however, considering he is so advanced in the other eye I thought it was best for CXL in the left eye sooner than later.
11:00 – 12:00 pm	**Jocelyn Ou, OD, FAAO** **Management of Severe Conjunctival Prolapse in Scleral Contact Lens Patien**	How long do you tell patients it takes to adapt to RGP lenses? Do you have them gradually increase wear or start wear full time right away?	It depends on the patient – but patients are usually able to adapt in 1-2 weeks. I tell ALL of my new wearers (regardless of corneal GP or scleral) to slowly build up their wear time – start with 2 or 3 hours on the first day, and build up 2 hours per day until they reach a full day.
		If you contour the patient's irregular corneal shape with an eyeprint lens, wouldn't this give them the same visual distortions they have without the lens in a way?	A very good question! In some ways, yes – that's why the eyeprint lens cannot be an exact mold/replica of the patient's ocular surface. While the design does allow for more ability to customize the contour of the contact lens, there is still a limit to how much you can manipulate the lens. However, keep in mind that it's not the shape of the scleral lens that's in play here – the tear/saline reservoir is very powerful in neutralizing the corneal irregularity.
		Hello! Could you give an estimate on the price for having an EyePrintPRO fit (per	Practitioner cost is $1800 per lens, and AVT generally recommends charging the

		eye)? Thank you!	patent $2500 per lens (material cost). This is not including the fitting fees – which are set by the practitioner. So the total cost varies based on the practitioner and severity of the case.
		Could you have done an EyePrint in case #1, GJ?	Yes, that definitely would have been an option!
1:00 – 2:00 pm	**Barbara Mihalik, OD, FAAO** **All About Central Serous Chorioretinopathy**	Did your first patient case have a refraction? Curious if he would have had a hyperopic shift?	No, they did not. They were 20/20 at distance in each eye. The fluid was inferior to the ONH so you would not expect a hyperopic shift since the macula was not involved. If the fluid was at the macula though, you would expect a hyperopic shift so good thought process.
		how can you tell the patient's has had previous episodes of CSR based on just the FAF? Is it the mottling appearance?	Correct. It is the other areas of mottling and granular hyper and hypo fluorescent patches on the FAF. This in addition to the main finding of sub-retinal fluid at the area of guttering makes you suspicious that the other areas are previous sites of CSR.
		Is hot spotting from iphone an option? I do that since my wifi is bad at my parent's house	Thank you for the suggestion! It was greatly appreciated.
		I would love another description of the guttering appearance on FAF, please! I wasn't able to see what exactly she was pointing to as the guttering.	It was the hyper-fluorescent area on FAF inf to the ONH OD. It is called guttering due to the tract pattern it makes on FAF and is a result of gravity pulling the subretinal fluid inferiorly.
		What else is in your differential diagnosis for this patient?	Wet AMD, choroidal tumor, Optic pit, and rhegmatogneous RD or RD due to mac hole. These are other main causes of subretinal fluid but not an exclusive list so you may have had other ideas as well and that is great. You could also include diagnoses that cause RPE mottling. See next answer below.
		What are all the causes for RPE mottling? I was familiar with ARMD of course, but what are the common causes besides ARMD and CSCR?	Some other causes of mottling could be scarring (from laser, trauma, retinal surgery, etc), various inherited retinal dystrophies like cone-rod and pattern dystrophies, pigmentary retinopathies (including bulls eye maculopathy) from toxic causes like medications and

			nutritional deprivations
2:00 – 3:00 pm	**Thomas Kozlowski, OD, FAAO** **Clinical Findings, Differential Diagnosis, & Management of Bacterial Keratitis**	Case One- generic slaine or generic MPDS?	Good catch - this patient was using **saline** to store his contact lenses. This was likely another factor that contributed to this patient developing bacterial keratitis.
		Since the patient's infiltrate stained, would that make it a sterile ulcer?	Staining does mean that it was an ulcer, but remember an ulcer can be sterile or infectious. A sterile ulcer (such as in the setting of Marginal Keratitis or contact lens-related (CLPU)) typically stains less than an infectious ulcer.
		would you still consider vigamox when BK is CLs induced ? since it's likely a gram negative cause	Clinical studies conclude that monotherapy with FQs is still an appropriate option in these patients. Due to the increased resistance profile and more aggressive pattern of infection, these patients should be monitored very carefully.
		How finaincially feasible is it for an independent OD to keep a cornea culturing kit? Is it something all new practices should have, or is it enough to have close ties to a corneal specialist?	Due to costs and limited shelf life, it is not feasible for all new practices to have. Close ties with a corneal specialist is often the preferred route unless you expect to see a high number of cases (high CL volume etc.).
		When do you consider bandage contact lenses with healing of epithelial defects? How would you manage instillation of Antibiotics with the bandage contact lens on?	Great question - I would consider adding a BCL when you are confident the infection has resolved, and you are only dealing with a poorly healing epithelial defect. Aggressive lubrication, including ointments, can be used to 'bridge the gap' until you are comfortable adding a BCL. I would recommend using prophylactic antibiotics any time a BCL is being worn, dosed QID. Amniotic membrane would be a good alternative option.
		If you were to refer to a corneal specialist at initial presentation, would you send for culture before starting an antibiotic or would you start the antibiotic ASAP? Thank you.	Very good question - I would still start antibiotics. It is still possible to get positive culture results if the patient is already on antibiotics. We want to prioritize patient outcome. Remember only 50-70% of cases will yield positive results anyway.
		Are you prescibing the ointment at night	Yes and yes! Antibiotic ointment QHS on

		instead of having the patient wake up throughout the night to continue using the drops? Do you ever have patients wake up throughout the night to continue the use of drops?	its own should be reserved for less severe cases, such as this one. In more severe cases the patient should continue antibiotics around-the-clock. Depending on the severity it may be reasonable to prescribe ointment and reduce the frequency of drops overnight (ex. Q2H instead of QH)
		With day 2 and especially day 4 edema remaining, would you consider adding a steroid at that point?	Very good question. While not unreasonable, I would not. On Day 4, the epithelial defect was only 50% healed, and adding a steroid may slow the healing process. Remember the cause of the edema is the infection - once the infection has resolved the edema will resolve as well.
		Just for a recap: the patient was kept on Vigamox q30 minutes x 4 days? Thanks!	Vigamox q30 minutes until Day 4, then QH until Day 7 (significant improvement at this point), then QID.
		How much did you taper the ab before d/c in 3 days?	Vigamox was maintained at QID until patient stopped. Remember do not taper below QID as this may increase resistance and is likely sub-therapeutic dosing.
		Could we get a copy of this presentation?	Certainly - please email me at tomkoz827@gmail.com to request a copy
		If you did RX cycloplegic for BK, when do you d/c?	Good question - and the answer is case-by-case. I would use patient symptoms and amount of inflammation present to determine when to stop the cycloplegic.
3:00 – 4:00 pm	**Alissa Coyne, OD, FAAO** **Spontaneous Hyphema**	Would you have dilated if his pupils were small?	Yes, dilation would be important in order to rule out other retinal issues that can be related to the underlying etiology of spontaneous hyphema. Cycloplegia is part of standard-of-care treatment associated with hyphema and can be combined with dilation at the presenting appointment. One could argue that I should have dilated him that same day; peripheral views were obtained at the 1-day follow-up in order to assess the peripheral retina for findings associated with sickle cell.
		Is 3- or 4- mirrior SOC when it comes to	Gonioscopy is standard-of-care in ruling

		evaluating for hyphema/AR?	out angle recession – no specific recommendation exists regarding 3-mirror or 4-mirror based on the Preferred Practice Patterns in optometry or ophthalmology. Always utilize caution before day 5 in order to decrease the likelihood of rebleed (or secondary hemorrhage) associated with putting pressure on the globe. The same recommendation also pertains to scleral depression.
		how cautious should you be when using steroid a hyphema patient?	Corticosteroids are standard of care in the treatment of hyphema to reduce inflammation and prevent posterior synechiae and peripheral anterior synechiae. Steroids also decrease the likelihood of rebleed via inhibition of fibrinolysis. There is controversy if topical ophthalmic steroids are as effective as systemic steroids in decreasing secondary hemorrhage rates. Prednisolone acetate 1.0% is typically dosed four times a day and tapered appropriately based on anterior chamber presentation. If an epithelial break is present due to the trauma, the prophylactic antibiotic coverage initiated will also assist in the coverage with corticosteroid use. If the practitioner is concerned regarding steroid response, remember it typically takes about 2 weeks for the first rise in IOP to be noted if a true steroid response. A small rise in IOP is beneficial in hyphema as it can assist in clearing the blood from the anterior chamber. However, small rises in IOP must be treated quickly in patients with SCD or SCT due to the likelihood of long-term damage to the optic nerve.
4:00 – 5:00 pm	**Ryan S Vida, OD, FAAO** **Small Incision Lecticule Extraction (SMILE)**	Is there any cases where we would recommend lasik over smile?	That is a tough question because there are so many factors that go in to making a decision for surgery. If we are talking about a standard perfect case with enough tissue and healthy cornea, one type of case/person comes to mind. We would consider performing LASIK in a patient that absolutely 100% has to get

			back to a huge work project or something extremely visually demanding the next day. By visually demanding, I dont mean a normal job that we all do. I mean a lawyer that is in the middle of the biggest case of his career and has trial the next morning or a surgeon that is operating the following morning. While nearly 90% of our SMILE patients see 20/20 the next morning, LASIK is even higher.
		What drops are patients put on post SMILE?	Patients use the same drops after SMILE as they do after LASIK. (i.e. Antibiotic and steroid for 1 week)
		is there any time LASIK would be better for the patient over SMILE?	See above
		Great presentation! Learned so much!	
5:00 – 6:00 pm	**Mika Moy, OD, FAAO** **Grand Rounds: Ocular Trauma**	Would you consider amniotic membrane for the abrasion?	I like amniotic membranes a lot and they definitely have their place in optometry. But, as I like to tell my students, you don't need a sledgehammer to kill a mosquito. Meaning—this abrasion will do great on its own with a bandage CL. What about long-term benefits? Would he be less likely to get a recurrent corneal erosion (RCE) if we used a membrane now? There isn't any research on that topic that I am aware of. But, as it turned out, he didn't get RCE and it's been about 5 years since this injury and he's still a patient of mine.
		tonometry over BCL what do you use? not GAT?	The study I cited used Goldmann applanation tonometry. This begs the question—am I going to use NaFl on top of a hydrogel CL? Sure! Why not? It just makes it yellow for a while. But, we actually did tonometry without NaFl in this case. You don't HAVE to use NaFl for tonometry—it just makes it easier. Use a white light and no dye one day, you'll see. And then you'll always use NaFl except in strange circumstances because it is so much easier.
		Can you do goldmann if there's a hyphema? and the cornea looks clear	This is a great question. In general, you don't want to manipulate the eye if at

			all possible because you don't want to do anything to possibly dislodge a clot and cause a rebleed. That's why gonioscopy is not done immediately. However, it is also important to monitor the IOP so you can take action if it starts to rise too high (remember the IOP is helping to keep the clot in place, so if it goes up to mid-20s we probably would just leave it alone). Personally, I think the risk of Goldmann tonometry is very low. So, I have no problem doing it over a hyphema. It would be reasonable to play the odds too—this is a microhyphema, so odds of increased IOP is very low, so I choose to do it very infrequently. But, then I'd say, this is a microhyphema. The odds of dislodging this tiny clot are very low, so why not do it?
		I really enjoyed both your lectures! truly informative and felt like I was criticlaly thinking through cases, something I definitely miss from rotations. We don't have access to these lectures afterwards, so I was wondering if you are able to email me the powerpoints. If not, I completely understand. Email: sbhutta@salus.edu	Hello! Thanks for your kind words! You made me smile. ☺ Your faculty do have access to these talks, although they do not have access to the Power Points. I don't want to inadvertently create a problem by sending an individual the slides and then the Academy has to deal with a lot of requests, so I'm going to decline. And, I would argue that you got the most out of this talk <u>during</u> the talk and making your brain think through the case like you would have in clinic! The rest of the stuff is easily looked up from other sources. So, from that perspective, you don't need the slides. ☺
		Will we be able to get the slides for these webinars?	See above answer
		Hey, so on the first patient when we checked their NPA. If they had absolutely no accommodation in that right eye. Is that when we would be worried about the uncal herniation?	If there is no accommodation in an eye with a blown pupil, the differential would include pharmacologic (parasympatholytic) or a compressive lesion which could include the starts of an uncal herniation. But remember, patients with a subdural hematoma are also going to have a bad headache, then feel sick, then pass out, then die (unless there is surgical intervention). So somewhere in there, their pupil will dilate. But, in this patient case, he's

			walking, talking and 3 months post injury with no headache. So, the accommodation test was really just a fun way to learn that point. It would likely never come up in real life.

SOCCEP Q/A
Thursday, April 9

Time	Session Details	Question	Answer
10:00 – 11:00 am	**Patricia Piers, PhD** **Intraocular Lens Optics and Design**	Patients always ask: will the lens "wear out". We say no, but what is the half-life of the lens materials? 100, 200 yrs??	Stability testing has been conducted according to ISO standards. The lifetime of an implanted intraocular lens is, at minimum, 20-40 years post implantation.
11:00 – 12:00 pm	**Reena Joseph. MPH, OD** **Astigmatism Management and Post Operative Troubleshooting**	Could we get a copy of this presentation thank you (Janice Lee: jl2325@mynsu.nova.edu)	Thank you for your request for the materials. Due to the proprietary nature of the content, Johnson & Johnson Vision is unable to release the PowerPoint presentations. Additionally, these sessions were recorded, and you may request access through your faculty members.
12:00 – 12:50 PM	**Noel Brennan, OD, PhD, FAAP** **Clinical Implications of Contact Lens Material Properties**	In our contact lens courses we learned that in EW/CW, incidence of MK is similar between SiHy and Hy lenses but the severity and loss of vision is significantly less in SiHys. Perhaps I missed it in your presentation, but is this still true or has new research come out that has disproved this?	Good question. This is a paragraph from Stapleton et al, 2013 Eye and Contact Lens and represents up to date information to the best of my understanding. "Vision loss is reported in 12%–14% of cases of CL-related microbial keratitis, and independent risk factors for vision loss include disease caused by an environmental pathogen and a delay in receiving appropriate treatment. CL material type is not associated with the frequency of vision loss. Where cases using extended wear CLs were matched for causative organism and treatment delay, there was a small but statistically significant reduction in disease duration in silicone hydrogel CL wearers. This is consistent with a

			finding of increased severity of hospital presenting corneal infiltrative events with hydrogel compared with silicone hydrogel extended wear." My conclusion... any differences between materials in regard to severity are probably of minimal importance.
		I may have missed this but does the coefficient of friction of a CL change as the patients wears them throughout the day, or a result of CL wearers with borderline dry eye etc?	Another good question. I do not believe there are any peer-reviewed reports to this effect. I recall an English researcher by name of Brian Tighe presented some data at a conference suggesting that there is an elevation with wear, but that the relative coefficients are maintained between lens types. Logically, you would imagine with deposition and drying of the lens surface that friction would increase!
1:00 – 2:00 pm	**Brian Pall, OD, FAAO** **Pediatrics and Contact Lenses & Ultraviolet Radiation and the Eye: Translating the Research into Practical Application**	What are your thoughts on the acuvue transitions?	Thank you for question. The content of these lectures is intended to be educational and non-promotional. As such, I am referring you to the following source to learn more about this technology: https://www.acuvue.com/acuvue-oasys-transition-contact-lenses. This source will provide you with balanced and referenced content as well as comprehensive safety information.
2:00 – 4:00 pm	**Kurt Moody, OD, FAAO** **OSD in Clinical Practice: Case Reviews**	Could you please repeat the website where I can access the case pdfs. Thank you!	Jnjvisionpro.com
		What factor was increased by 2.5X in the Asian population? Thank you!	Jenifer Craig, from New Zealand ran the study. She found the Asian ethnicity group had a 2.5X increase in prevalence. A post hoc analysis indicated it was due to a reduced

			blink rate and an increase in incomplete blinks (Craig JP, Lim J, Han A, Tien L, Xue AL, Wang MTM. Ethnic differences between the Asian and Caucasian ocular surface: A co-located adult migrant population cohort study. Ocul Surf. 2019;17(1):83–88. doi:10.1016/j.jtos.2018.09.005)
		Where would I be able to find a MG evaluator? I am Canadian and I think there is no shipping to Canada	These are available on the JJV Professional site (https://www.jnjvisionpro.ca/)
		When do you introduce doxycycline as an anti-inflammatory agent? At what dosage/ frequency/ duration?	Per the MGD workshop there are a variety of adjunctive treatments that can be very important in MGD management. These adjunctive treatments include artificial tears, warm compresses, topical and systemic medications, and others. The decision regarding what to use and when depends on the particular case and what is being treated in addition to MGD. Important to note is that the use of topical antibiotics for the management of MGD is off label. (Reference: Geerling G, Tauber J, Baudouin C, et al. The international workshop on meibomian gland dysfunction: report of the subcommittee on management and treatment of meibomian gland dysfunction. Invest Ophthalmol Vis Sci. 2011;52(4):2050–2064. Published 2011 Mar 30. doi:10.1167/iovs.10-6997g)
		Why did we use the lotemax after lipiflow?	Per the MGD workshop there are a variety of adjunctive treatments that can be very important in MGD management. These adjunctive treatments include artificial tears, warm compresses, topical and systemic medications, and others. The decision regarding what to use and when depends on the particular case and what is being treated in

			addition to MGD. (Reference: Geerling G, Tauber J, Baudouin C, et al. The international workshop on meibomian gland dysfunction: report of the subcommittee on management and treatment of meibomian gland dysfunction. Invest Ophthalmol Vis Sci. 2011;52(4):2050–2064. Published 2011 Mar 30. doi:10.1167/iovs.10-6997g)
4:00 – 5:00 pm	**Hong Fu, PhD** **Laser Application in Corneal Refractive Surgery**	No questions	
5:00 – 6:00 PM	**Sanjeev Kasthurirangan, BS (Optom), PhD** **Clinical Evaluation of Refractive Surgery**	What is the maximum myopic refractive prescription?	For modern refractive surgery platforms, the highest indicated range is –11D spherical equivalent for wavefront guided LASIK. Previously with conventional LASIK and PRK up to –14D was approved, but infrequently used. The key limiting consideration for the amount of refractive error treated is the residual corneal stroma left after surgery and the safety limit is at least 250 microns, but preferably 300 microns of tissue left.

SOCCEP Q/A
Friday, April 10

Time	Session Details	Question	Answer
9:00 – 10:00 am	**Jocelyn Ou, OD, FAAO** **Medical Management of Corneal Transplants**	Did you have the patient for case 1 continue PRED OD in addition to poly trim?	In this case, I took the patient off of Pred until she saw her corneal surgeon. There would be 1-2 days without her seeing an OD or MD, so I wanted to decrease the risk of an infection setting in. Plus, since the pred was for transplant rejection prophylaxis, not using the drop for 1 or 2 days wouldn't change too much – and if a rejection was about to set in due to the amount of inflammation that was going on from the broekn suture, the one drop of pred wouldn't do much in helping to save the transplant.
		I think I missed it but what did she decide to do with the corneal neo?	For case 1? I unfortunaely was unable to see the patient back for follow up prior to me leaving my residency, however I did call her and her surgeon to see how she was doing. The surgeon did remove many sutures, and with the irritation from the broken and loose sutures gone, the neo vessels shouldn't get worse – and may regress over time as well.
		What is the purpose of the oral acetozolamide for wound dehiscence?	Oral acetazolamide would be used to decrease the pressure within the eye, in theory to help the wound re-seal.
		1. Other corneal options: Melles describes a Bowman's layer (acellular) transplant for progressive keratoconus. Also in selective cases with certain posterior corneal path you can strip Descemets and endo without replacement in a small area of treatment. 2. Interesting Q: Can CLs cause a rejection episode?	1. Yes! Bowman's layer transplant is definitely a very new technique in possibly managing severe keratoconus – possibly having all of the benefits of a full-thickness graft without all the risks tha come with a PK! Only a few surgeons are performing this technique right now, so we'll have to see the long-term efficacy! 2. I am hesitant to say that CLs can be a precipitating effect to a rejection, as it is widely documented that CLs are safe to fit and wear post-PK. However, if a lens is fit improperly, causing a lot of irritation (mechanical and/or hypoxic), it would definitely be on my list of differentials for why the rejection began! I wouldn't imagine there'd be a way to prove it though.

		Would a GP lens be better for transplants? Is there a chance that the edge of the GP lens could rub against the sutures with blink and over time loosen the sutures due to mechanical stress?	I always like to fit corneal GPs when I can, especially on graft eyes, as they provide a lot more oxygen to the ocular surface vs. a scleral. There definitely is a risk for rubbing at the graft host junction though, and if the sutures are not well re-epithelialized it can definitely cause them to loosen. However, once the sutures/ocular surface are stable, it's rare for the sutures to become loose. If the sutures were to become loose/break – it likely wouldn't be a gradual erosion over time, it would be a spontaneous event. The risk is always still going to be there regardless of how stable the surface is – our patient in case 1 had her PK years ago and was stable, and wasn't a CL wearer but a suture did still break.
		Why do younger patients have a higher chance of rejection?	Younger patients have a more robust immune system compared to older patients, so they have a higher likelihood of inciting a rejection response.
		how important is it to have corneal transplant pts wear UV protection/sunglasses all the time?	The need for UV protection would be the same as the general population.
10:00 – 11:00 am	**Kevin Chan, OD, MS, FAAO** **Proactive Myopia Management: Orthokeratology Lens Fitting for Astigamatic Patients**	Is there a possibility of inducing astigmatism with pressure when lifting the eyelid to measure limbal-limbal astigmatism?	Probably if the pressure is applied on the globe. You may see an atypical steep indentation at 12 o'clock position for which can be misinterpreted as limbal-limbal astigmatism. So, it is best recommended to hold the upper lids against the orbital arches instead of being on the globe to minimize induced astigmatism.
		Hi, how far away from central cornea is the point where the sagittal height measured?	Typically at 8mm chord length in total. In other words, it is approximately 4mm from the central cornea to each quadrant of the limbus. That said, it is not always doable because some lid apertures are anatomically narrow. So, the best possible chord length for SHD can be <8mm.
		Hi, for the central island, there is not enough flattening in the treatment zone,	Good question. While base curve is the key parameter to achieve proper target

		so why would we opt to flatten the reverse curve instead of changing the treatment zone/base curve?	Rx without optical correction during daytime, BC has little bearing in lens position. Please note that ortho-k works by hydraulic equilibrium (not direct flattening of the cornea). In order to address the central island, we actually have to flatten the reverse curve so that we can increase the "pulling" hydraulic effect in mid-periphery. Think of it like a 'see-saw' balancing effect among all curve parameters in ortho-k lens design
		Up to what level of asitgmatism can you treat with the lenses?	Typically <1.50D WTR and <0.75D ATR (a slide has shown the details). Yet, in some cases, patients can be fit with higher level of toric ortho-k design to optimize lens centration and stabilit (though used as off-label).
1:00 – 2:00 pm	**Pierce Kenworthy, OD, FAAO** **Grand Round: Epidemic Fidgets**	The slide with "pointy" lashes is very suggestive of ADV as well as the follicles.	Yes! Great observation, there can at times be so much serous discharge that clusters of lashes bunch together in little pointy stalactite type things. And **follicles** are a clinical hallmark of viral conjunctivitis, so these are all pointing us towards a diagnosis of ADV. Well done!
		If a patient waits to seek care, how long of a time period do we have to remove the pseudomembrane?	Great question! I do not have an exact timeline. I think the following article has some great explanations of EKC. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3880539/ "The onset of EKC may seem rapid to the patient, but in reality, there is an incubation period of about one week before the clinical symptoms present.[12] The second eye is often affected days later to a much lesser degree.[13] The period of communicability is from late in the incubation phase up to 14 days after the onset of the disease.[14] This acute phase of EKC is marked by a severe conjunctivitis and lasts from two to four weeks.[14] After the conjunctivitis appears, there is a period

			of viral shedding where the self-limiting virus is gradually cleared from its host.[12] However, before the virus is completely shed, the inflammatory reaction of the conjunctiva can become so intense that it results in a pseudomembrane and potentially permanent symblepharon formation or punctual occlusion.[6,12] A specific timeline is not given (just says "before the virus is completely shed", but I would say the sooner you remove the pseudomembrane the better! If the patient was being treated with corticosteroids, that may suppress the inflammatory response enough to prevent the more significant sequelae (like symplepharon), but this will be a case by case scenario.
		Would antivirals ever have been indicated in this case? I don't think I've ever fully understood why we don't seem to use them in viral conjunctivitis, even when it's fairly severe. In addition, would you have used a povidone-iodine wash if you had seen the patient earlier?	I have heard of idoxuridine and cidofovir being used, but this is mostly done in clinical trials. Some clinical studies have also attempted combining ganciclovir with povidone-iodine. The big reason antivirals are not used for adenovirus is the TOXICITY of these drugs. The second reason is they just aren't as effective against adenovirus as they might be for other viruses like herpes. I came across a good article about this: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6054290/ "There is currently no FDA-approved treatment for ocular HAdV. However, antiviral drugs, such as ganciclovir and cidofovir, have demonstrated promise in the treatment of various HAdV types with in vitro studies.53 Cidofovir is a nucleoside analog that was developed to fight against DNA viruses, as it directly passes the cell membrane and targets the DNA polymerase of the virus to halt replication.126 Topical application to the ocular surface reduces time and exposure of viral shedding. The **utilization of cidofovir for the treatment of HAdV is controversial, as studies have not exhibited a statistically significant**

			improvement in the amelioration of symptoms or course of the disease.2,53 It has also been demonstrated **to cause substantial ocular toxicity,** even at low doses, making it of little clinical value.127,128 Ganciclovir is also a synthetic nucleoside analog inhibiting DNA polymerase and effective against several DNA viruses, most notably the herpes family.53,129 **The marginal efficacy of ganciclovir in treating adenoviral keratoconjunctivitis could be attributed to the lack of viral thymidine kinase in AdV**.6,129,130" So while some of these meds are highly effective against herpes virus, we don't see as much benefit on adenovirus. Regarding the timing of povidone-iodine wash, definitely would have considered it if the patient was seen sooner (probably within the first week of presentation)!
2:00 – 3:00 pm	Mark Risher /Justin Rienzo Helping Patients Get Access to the Medicine Prescribed	Where can we get access to the Allergan call-back flashcard?	This was already provided and was e-mailed out by Jo Laborde to all the attendees
		I missed the website that will help understand this more — on the previous slide	www.covermymeds.com
		Are there any savings programs for patients without insurance?	www.rxhope.com
		Could you please give us a little more information on what documentation is necessary to be submitted to the pharmacy for step-edit based medications?	Previous mediations tried and failed is the primary information needed.
		I would like the pdf of the card! vbrooks@sco.edu	This was already provided and was e-mailed out by Jo Laborde to all the attendees—the same info referenced above that Jo sent out.
4:00 – 5:00 pm		Why was timolol chosen as the topical	Timolol is often used as a standard

	Mark Risher / Dr. Aman Mahil- Biosketch New Novel Treatment of Glaucoma	drop? Can't it have a reduction in IOP in the fellow eye due to systemic absorption?	comparator for IOP-lowering registration studies. Timolol was used in the fellow eyes of those who received the implant and in both eyes of those in the control arm of the studies. Based on the study design and biostatistical considerations, it is not expected that the use of Timolol in the fellow eyes will have an impact on the study outcome.
		Unsure if this was already answered, but how long do the effects of durysta last? (e.g. 1 year, 2 years?)	Of those who received a single 10 mcg administration at baseline of the phase 1/2 studies, 24% did not require additional IOP lowering intervention at 24 months (study conclusion).
		Sorry if I missed it, can patients who have had an SLT or ALT treatment get the implant?	There is no contraindication to these procedures per the FDA approved prescribing information.
		If there is an adverse affect, how is the procedure reversed?	Adverse events can be managed as per the treating clinician's standard of care.