SOCCEP Q/A
Monday, April 20

Time	Session Details	Question	Answer
9:00 – 10:00 AM	**Andrew Meagher, OD, FAAO** **A Crash Course in MIGS**	Is there any contraindication to doing an MRI with iStents (certain tesla limit?) since the device is titanium. Concern for sahift/malposition	A patient with an iStent (or iStent inject) can safely have an MRI with a 3T limit. It was also found to not have a clinically significant rise in temperature after 15 mins of continuous scanning. If there is a concern of image artifact, in non-clinical testing the found the artifact to be less than 15mm. Hope that helps!
		If we can identify outflow differentials down the road should we place the device in the arera with most or least area of outflow.	There's limited info out there but the earliest findings show to place the MIGS in the area of greatest outflow—inf-nasal/nasal, this is also the area of largest espiscleral venous collector channels. With limited data it will be interesting to see with advancements in aqueous angiography if this varies patient to patient if they ever develop an in OR method to perform just prior or during their cataract surgery.
		If someone has an iStent, can they have an MRI?	A patient with an iStent (or iStent inject) can safely have an MRI with a 3T limit. It was also found to not have a clinically significant rise in temperature after 15 mins of continuous scanning. If there is a concern of image artifact, in non-clinical testing the found the artifact to be less than 15mm. Hope that helps!
		You mentioned that most MIGS are placed nasally because of the incisions. With the iStent inject, are the 2 placed in the same quadrant? Is the goal for iStent infinite to put 3 in the same quadrant?	From all the surgeries and videos I've seen they are placed roughly 2-3 clock hours apart—I've never seem then closely neighboring one another
		What % of Xengels need to be "needled" ?	In my personal experience—none. But I've reached out to one of the surgeons I work closely with to ask if she has experienced the need for any.
		How significant is the inflammation after a Kahook, canaloplasty, or GATT procedure? How long does it usually take to resolve?	In my experience I have not seen any more inflammation that what one would see with traditional post-op cataract surgery. To add to that I've attached a a good article that provides a bit more insight, specifically Figure 2. link: https://www.ncbi.nlm.nih.gov/pmc/arti

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		Can you repeat again which ones can be perfromed independent of cataract surgery?	At the moment the approved standalones are: Kahook dual blade, Xengel, viscocanaloplasty, approved **only** during cataract surgery are: hydrus, iStent G1, iStent inject, Cypass (no longer on market) and I presume the iStent Supra is slated to be approved Hope that helps!
		What is the typical post-op management for patients that have MIGs procedures? Drops similar to post-op cataract management?	The post op management is exactly the same. What I note in my chart when I view them gonioscopically is that the device is well placed with no debris or synechiae. Hope that helps!
		In your experience are the effects of MIGs long lasting or is there a regression in IOP reduction? You mentioned with the hydrus that the one study showed consistency in the reduction 2 years after, is this what you have observed?	In my experience the majority have the best response within the first 6 months or so, some go much much longer and some regress but in all cases their IOP remains lower than what it was before (with use of same drops pre-surgery). Any mmHg counts!
10:00 – 11:00 am	**Sulman Hans, OD, FAAO** **Pseudoexfoliative Glaucoma**	No questions	
11:00 – 12:00 pm	**Donna Wicker, OD, FAAO** **Coping with Aniridia for a Lifetime: How Ups and Downs of Vision Loss Impact Independence**	What cause corneal clouding? Is it related to secondary glaucoma? Is there treatment for corneal clouding?	Aniridia patients can have poorly developed angles, leading to secondary glaucoma. Also here limbal stem cell deficiency caused dry eye syndrome, corneal decompensation and clouding. Treating dry eye includes rewetting drops and scleral lenses as for this patient. Amniotic membranes or corneal transplants may also be an option
		What is +12 prism reader? How to come up with this reader?	Power of 12 with 14 prism diopters base in so that the patient does not have to converge so close. In general magnification needed = ability/goal using M notation or letter size or Snellen denominator

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		Would you mind going into a little more detail about PROSE? I'm not familiar with this.	PROSE is the customized design scleral lens from the Boston Foundation, used to be call Boston lens. Can customize fit more than other scleral lenses
		Can cosmetic contact lenses play a role in aniridia?	Yes, iris printed lenses can be helpful in aniridia patients with photophobia
1:00 – 2:00 pm	**Bryce St. Clair, OD** **Spot the Difference: Differentiating Nevi, CHRPE, Melanomas & Melanocytomas**	for Large melanomas - does the 27% mortality rate apply after the enucleation? or is this just in general whether you enucleate or not?	This is after enucleation. The patient still has a 27% chance of mortality even after the eye is enucleated with the melanoma inside. This is because the surgery itself can cause the cells to seed elsewhere in the body by entering the bloodstream.
		Could you please descibe hwat orange pigmetn is?	Orange pigment is the lipofuscin, which is the lysosomal waste of an actively metabolic lesion. In the case for choroidal melanomas, lipofuscin is a telltale sign that the retinal lesion is a melanoma and NOT a nevus.
2:00 – 3:00 pm	**Richard Shuldiner, OD, FAAO** **Low Vision Exam: Testing Procedures**	Is telescopic vergence corrected by the focusing function on telescopes?	If it is a focusable telescope, yes.
		Do you measure contrast during the intial exmination?	No. Since there is pretty much no means of improving it, I have no reason to do it. And I can tell if it is the major issue of the patient just by listening to the patient.
		I know you'll be forwarding the slides. Is it possible to get the video that Dr. Shuldiner is playing as well?	Yes, let me know where/how to send it.
3:00 – 4:00 pm	**Justin Alexander Schweitzer, OD, FAAO** **Discover Lotemax SM – Submicron Strong**	No questions	
4:00 – 5:00 pm	**Murray Fingeret, OD, FAAO**	How would you judge the comparative efficacy of Vyzulta compared to another newly released dual-mechanism IOP	Deciding upon using a medication is complex, based upon the person's IOP, eye history, medical history, severity of

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	Expand the Trabecular Meshwork with the power of Nitric Oxide	lowering drop such as Roclatan? When would you decide to use one over the other?	glaucoma, insurance coverage.
		Why was Vyzulta introduced with Latanoprost? Why not a single nitric oxide IOP drug?	Nitric oxide alone does not reduce IOP sufficiently nor penetrate the IOP. It is the combining it with another molecule to create the dual mechanism of action that is unique and important
5:00 – 6:00 pm	**Josh Richard Davidson, OD, FAAO** **Refractive Cataract Surgery Success post PKP**	do you have to taper the combination drop?	Yep. We like to taper them. We start the typical patient off on them TID for 1 week. If we see improvement, incision site healing, as well as a reduction in cell/flare, we then taper to BID for the next 3 weeks. From there, if all looks good, we simply discontinue it. Great question!

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Time	Session Details	Question	Answer
9:00 – 10:00 AM	**Ken Wan, OD, FAAO** **Dealing with Orbital Trauma without Batting an Eye**	Any contraindications for dilating with hyphema? Ie, if >50% bleed, is it still ok to dilate?	I didn't find any mention of a threshold over which you shouldn't dilate a hyphema patient in my literature search.
		How do optometrists send patients to be inpatients? Do we refer to a hospital primary care doctor with recommendations for bed rest? Or do we send to ER with these recommendations?	I would call the hospital and ask how they would want you to proceed. It may be different depending on the institutions around you what their protocols are. I've never had to do that so I have no experience other than to tell you that's what literature suggests.
		If corneal staining does not resolve in a few years, would you send for a corneal transplant?	Penetrating keratoplasty is an option but given enough time the majority of cases will slowly resolve first peripherally then centrally.
		Could you repeat what you mentioned about it not being neccesary to prescribe systemic antibiotics in orbital fractures?	There aren't many studies I found on the subject but the biggest study I found was the 2005 Australian study. They found that in a group of 497 orbital fracture patients who were prescribed antibiotics at the discretion of the treating physician (i.e. allowing docs to do what they normally would), 4 (0.8%) patients developed orbital cellulitis. This doesn't answer the question of how effective the systemic antibiotics were unless you knew how many of the 497 received antibiotics. Another author reported on this data set and using the assumption that 90% received antibiotics, you would get a number needed to treat (NNT) of 75, meaning if you treat 75 fractures with antibiotics, one of them would be spared an orbital cellulitis that would otherwise have occurred without antibiotics. Conversely, a assuming they prescribed to 60% would get a number needed to harm (NNH) of 198, causing 1 in 198 fractures to get an infection they would otherwise have avoided (i.e. due to antibiotic resistance encouraged by the practice). Looking at the 4 patients with orbital cellulitis, 3 of them were already on antibiotics so that casts even more doubt that this is truly an effective treatment.

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			I don't recall the source but I believe the rate of antibiotic prescribing is closer to 48-50% in the US, so if you make the assumption that the US and Australia prescribe similarly, it's suggestive that systemic antibiotics on average are not improving patient outcomes and may be harmful. This is not taking into account individual patient variability of course. If you have a patient with clearly an open wound or are immunosuppressed then it wouldn't be wrong to prescribe, just not as a blanket practice on every fracture that occurs.
10:00 – 11:00 am	**Mark Wilkinson, OD, FAAO** **Your Role in Rating Visual Impairments/Disabilities**	No Questions	
11:00 – 12:00 pm	**Derek Cunningham, OD, FAAO** **Prepping the Cornea for Refractive Surgery**	While it may vary patient to patient, on average how long do you feel like it takes to prepare the surface of the eye?	We like to plan for at least 6 weeks for most patients.
		Is there any information on whether or not light adjustable IOLs are better or worse for patients with OSD?	In our experience they have been better because it allows us to adjust for any residual refractive issues after the surgery.
		Did you have this patient stop using her eyelash growth serum?	If the dry eye is significant, we will temporarily have the patient discontinue the serum until the ocular surface disease is better controlled.
		Which steroid do you use for ocular rosacea?	We typically us loteprednol steroids for all ocular surface disease due to their safety profile.
		What kind of steroid do you like to put the patient on	We typically us loteprednol steroids for all ocular surface disease due to their safety profile.
		What are your recommendations for patients that regularly want eye lash extensions?	For severe dry eye, not a good idea. Form mild to moderate dry eye, the important information to convey is that it makes their dry eye worse. If the patient understands that treatments will be less effective with the lashes, we work around them.

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		Not a question, but this was a FANTASTIC lecture! How can we connect with you?	Derek.n.cunningham@gmail.com
1:00 – 2:00 pm	**Anita Gulmiri, OD, FAAO** **Case Series: Prosthetic Contact Lenses**	For these patients who have extremely damaged cornea, how do you go about determing contact lens related complications that may affect the cornea more?	It depends on the functionality of the eye. A lot of times, these patients are NLP or LP, in which case they have severe ocular disease with dense corneal opacities, scarring, neovasc and so I'm less likely to worry about their corneal health. In cases where there is a functional eye, you do need to have a closer follow up for these patients, every 3-6 months depending on your comfort for their level of compliance and corneal tolerance.
2:00 – 3:00 pm	**Sowmya Srinivas, OD, FAAO** **Sympathetic Ophthalmia**	What was the main risk factor for developing SO?	Injury (most common) and surgery (less common are risk factors for developing SO
		What condition associated with SO do you not want to treat with steroids?	It is not associated but rather a different diagnosis that we have to rule out other causes of infectious granulomatous uveitis. Again must rule this out prior to treatment for SO due to worsening of infection with steroid use.e
3:00 – 4:00 pm	**Paul M Karpecki, OD, FAAO** **An Advance in Redness Relief: Low-dose Brimonidine Tartrate 0.025%**	Have you found any differences in efficacy in individuals of varying races?	No significant differences. Highly pigmented conjunctiva (melanosis) often doesn't appear as white but no difference in effects on the capillary bed
		Is Lumify still effective in reducing ocular redness for patients who are already on Brimonidine 0.2% for glaucoma treatment?	No, high doses of brimonidine will not blanch the conjunctiva and since we're adding .025% concentration in Lumify to Brimonidine (.2%) the total is 0.225% and that exceeds the low concentration necessary for whitening.
		Do you have any suggestions for reducing redness for someone who has found themselves to be allergic to Lumify?	The are probably allergic to the BAK in Lumify. A preservative-free version is expected to become available in 6-12 months otherwise consider a short term course of corticosteroids.
		What would you say to a diabetic patient	That would be fine but try to use the

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		receiving intraocular injections resulting in red eyes wanting to use lumify to decrease redness. would you advise? or ask them to refer to their ophthalmologist advice	drops on days that the injection is not taking place
		Have you found Lumify to be effective for a vascularized pterygium?	Only moderately, any areas with a capillary bed improve but the large corneal vessels improve minimally.
4:00 – 5:00 pm	**Shivani Sharma, OD, FAAO** **Limbal Stem Cell Deficiency: Case Reports and a Review of the Literature**	What causes the stippling pattern of nafl staining?	Answer: The stippled staining in the late stage is observed due to the loss of cell to cell tight junctions. This leads to staining of the basement membrane which presents as the “stippled staining.” The abnormal epithelium and irregularities in the epithelium also contribute to this specific staining pattern.
		Can you repeat how OCT is helpful in diagnosing this condition?	This paper details how OCT is used in diagnosing and understanding the pathology in LSCD. https://www.sciencedirect.com/science/article/pii/S Specifically, ant. segment OCT can help measure epithelium thickness, can help visualize the presence or lack of the palisades of Vogt. Spectral domain OCT has also been shown to have the ability to display a 3D structure of the limbal niche- including visualization of palisades of vogt, blood vessels, and lymphatic tissue. OCT has been very helpful in helping us understand the morphology of the biological tissue and visualize differences in the normal and abnormal limbal stem cell niche.

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Wednesday, April 22

Time	Session Details	Question	Answer
9:00 – 10:00 AM	**Erin Kenny, OD, FAAO** **Central Vision Loss and Driving: Options and Considerations for Our Visually Impaired Patients**	You said in PA requirements for bioptics are on case by case basis… Have you had difficulty getting them approved before? If so, what was the limitation in that case?	Pennsylvania does not allow the use of the bioptic to pass the visual acuity portion of the examination, so I find that I can only recommend bioptics to patients who are already driving (more than likely on a restricted license). I have not had any difficulty with the state with making those recommendations to this point. However, it is crucial the appropriate rehabilitation is delivered.
10:00 – 11:00 am	**Kelsey Moody Mileski, OD, FAAO** **Spontaneous CRAO**	Did you feel the C/D asymmetry was due to CRAO or can we start going down the road for glaucoma suspect as well?	No, you shouldn't see a physical change to the nerve (cupping or pallor) until 4-6 weeks after the event. We could start going down the glaucoma suspect, however, it will be slightly hard to initially differentiate what's potentially glaucomatous versus what's damage from the CRAO. The biggest thing to look for is change over time. If there is change then we can start to think glaucoma.
		Wow what a recovery in vision! Is visual prognosis just luck of the draw then? Because sending to get testing is not directly improving their vision, just getting more information. Do practitioners still do digital massage? Thanks!	Currently there is no treatment that is beneficial compared to the natural history of the disease. Meaning most patients with NON-arteritic CRAO do improve some, but usually still have a BCVA of 20/200 or worse. The goal of sending for testing is to potentially save their life. There is a significant risk of a second event, either stroke or heart attack within 30 days of the event, with the highest incidence within the first 7 days. Some practitioners may try lowering the IOP with digital massage, IOP lowering drops or paracentesis, but I wouldn't refer to retina because there is no intervention. When the patient leaves your exam chair, they should go to the ER.
		How would the management plan and prognosis differ if it were a BRAO instead? Is it still emerg referral to ER?	No difference! They still should go to the ER. I sent someone to the ER this week with a sub-acute BRAO. This is

			also true for transient monocular vision loss. The AHA indication is for any episode of retinal ischemia. The tough part is when an asymptomatic patient comes in and a hollenhorst plaque is seen. The problem is, is that you don't know when the event occurred, so you have to assume it could be acute and still recommend going to the ER.
		Why do CRAO pts get a central scotoma if the fovea has a different blood supply? I forget.	That's a great anatomical question. Think of it as the entire macula is still ischemic even though the fovea may not be. Also, those connections from the foveal to the optic nerve may not be received now. Think of it as the connection being off. Whereas with a cilioretinal artery there is almost a path from the nerve to the part of the retina that is supplied.
		What are you testin for hypercoag states and for whom?	I would test anyone who is younger (<50) and/or who does not have vasculopathic risk factors. Looking for lupus, antiphospholipid syndrome, factor V leiden, protein C/S deficiency, homocystinemia and antithrombin deficiency. Don't forget there are other conditions that can cause a hypercoaguable state (pregnancy, cancer, multiple myeloma, etc.)
		If you'd be willing to share your powerpoints, that would be fantastic! This is great information!	I can send it to you individually if you want to send me your email.
		so should we be doing gonioscopy after 4 weeks of CRAO like we do with CRVO?	Yes! The chance of getting neovascularization in a CRAO or BRAO is less than a vein occlusion but it can still occur. Think of it this way, when you get a vein occlusion, the retina may be ischemic but it is still alive so it can send VEGF however, in a CRAO, (sometimes) the retina is dead (to a degree) and can't typically send VEGF.
11:00 – 12:00 pm	**Hashim Ali Khan, OD, FAAO Optometrist & Von Hippel Lindau Syndrome**	No Questions	

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1:00 – 2:00 pm	**Richard Shuldiner, OD, FAAO** **Low Vision: What to Prescribe When**	do you need to put prism in for a +4, and the prism for +10 would be 12BI per eye or 12BI total?	Yes. And it comes ready made. And, yes, that amount of prism OU. Which is why I rarely Rx over +8 binocular.
2:00 – 3:00 pm	**Barbara Mihalik, OD, FAAO** **I'm a young diabetic, I see fine, so my eyes are healthy, right?**	are diabetics only required to dilate (as compared to photos) if the exam is being covered by medicare?	To be quite honest, I am not sure of that answer. But, I can tell you that I dilate every diabetic patient every time I see them. I also dilate all new patients and everyone else at least once a year. I get imaging just to supplement and to help give me a heads up about what I am going to be seeing. I had a great optom professor who used to say: you won't find things if you don't look for them ☺
		Any tips on how to diferentiate between MAs and DB hemes?	MAs are very very tiny and take a lot of effort to find them. So if you easily see a heme spot then that is most likely a DB heme
		For vitrectomy what is the vitreous replaced with typically?	A saline type solution is used and overtime itnaturally gets replaced with the eye's aqueous humour
		How are you educating these patients when they are first diagnosed with diabetic retinopathy? What is a good way to portray how serious it is without scaring them?	Good question. I have found that being straightforward, but, hopeful is the best way. I always like to tell them what DM does to the blood vessels in general and that we can gauge how the whole body is doing by looking at the vessels in the eyes. If they have retinopathy I like to show them what a healthy eye should look like and what it could look like at its worst (PDR) (I just google images to show them). Then I am very up front with them. If not to where they need treatment yet then there is a chance with good BS control that it can heal. If it worsens then I let them know that it can lead to blindness that is permanent since often treatment is to try and slow it down. The key is just educating them because often times they have no idea what can happen to their eyes and most people value their vision.
3:00 – 4:00 pm	**Timothy Hug, OD, FAAO** **Concurrent Amblyopia**	How young can you fit a patient with a scleral lens? Would she have been a good candidate?	We have successfully fit 6 and 7 year old patients with a scleral lens. I don't feel this patient would benefit from a scleral

			as her refractive error only had astigmatism without irregular corneal surface, as with some scarring.
		Thanks! One more question- due to the recurrent nature of her keratitis and scarring, would you refer for corneal crosslinking?	No current evidence suggests a benefit from crosslinking in these patients.
		What about causing amblyopia in the other eye?	Occlusion amblyopia is a risk factor in managing any amblyopia, close monitoring (q 4 weeks) can help early detection, but the decision to maximally treat was a greater concern…to see if vision loss was amblyopia or pathology
		What materials do you prefer to use for patching i.e. patching over specs? Under specs? Any brand name products you recommend?	My personal preference is any adhesive patch on the eye directly (instead of over glasses) to ensure maximal compliance to treatment.
		Do you have the patient patch every day or just a few days a week with FTO?	I will use daily patching when I use FTO, and monitor every 4 weeks
		What is the follow-up interval when we monitor regression of amblyopia thearpy?	The peak incidence of regression in between 3 – 6 months after discontinuing treatment. My preference is to monitor at follow up every 3 months for the first year.
4:00 – 5:00 pm	**Phillip Yuhas, OD, PhD, FAAO** **Preceptal Cellutitis: What To Do When Treatment Fails**	For internal hordeolum, would you consider warm compresses as a treatment in conjunction with antibiotic	Yes, warm compresses may facilitate drainage by softening the granuloma associated with the hordeolum
		How can preseptal cellulitis affected both upper and lower eyelids? When I see multiple internal hordeolum with lid warmth, I call it preseptal cellulitis. Am I correct?	There is no physical barrier separating the upper and lower eyelids; thus, an infection in one can (but doesn't have to) spread to the other. You can have multiple discrete hordeola without having preseptal cellulitis. The difference is that in hordeola, the infection is contained within a gland, but in preseptal cellulitis, the infection spreads to the rest of the eyelid tissues.
		How can you differentiate preseptal cellulites and allergic dermatitis in one eye only due to insect bite or anything else in one eye only	A good history, including asking about bug bites and foreign bodies in the eye, is a good start. Also, a careful inspection of the eyelid with the appropriate magnification (10-16x) and brightness (not too bright as to wash-out the image) on your slit lamp is also an

			important step.
		Have you seen PA nodes with hordeola?	I have not seen (+) PAN with hordeola. I suppose it's possible, but it would have to be a severe infection with a large inflammatory response.
		Would discontinuing augmentin and beginning doxycycline instead be an acceptable treatment?	As I presented, doxycycline is secondary option, best utilized when your patient has a sulfa allergy. It is not as effective against MRSA as Bactrim, and it has a laundry list of side effects.
		What is the next medication you would use if this patient did have a sulfa allergy?	I would go with doxycycline. It has some effectivity against MRSA. If doxy failed, I would refer because the patient may need intravenous vanco.

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Thursday, April 16

Time	Session Details	Question	Answer
10:00 – 11:50 am	**Vidhya Vilupuru, OD, PhD** **Fundamentals of Clinical Research and Role of Optometrists- Part I & II**	No Questions	
12:00 – 12:50 PM	**Elizabeth Dow, OD, FAAO** **CL Related Adverse Events: Diagnosis and Treatment. Bandage Lens Case Studies.**	For case #1 was there a reason an antihistamine/mast cell stabilizer wasn't used?	Thank you for this great question. In this case, a steroid was used due to the severity of the GPC and related lid edema and pain. Antihistamine/mast cell stabilizers have been shown to be successful in GPC treatment.
		How do you know when a cornea can be debrided safely?	In this case, there was no sign of infection. I have seen cases where very serious active infections were debrided/scraped in the corneal surgeon's office. Those were however cases that I would not personally treat but send to a cornea specialist as well.
		did you see this RCE patient on day 2 or day 3?	I saw the RCE patient on Day 1, 2, 4 and thereafter, not included in this presentation. I included photos from days 1 and 4.
		What is the best way to remove a BCL?	Thank you for this question. It's important that the lens is hydrated and not adherent to the cornea. I will typically first instill non-preserved artificial tears to loosen the lens. I ask the patient to blink to ensure good movement, then I will then slide the lens temporally very gently off the cornea and remove. Depending on the case, you might use your thoroughly washed hand, sterile glove, or disposable plastic tipped contact lens tweezers. This decision would be driven by the state of the cornea and/or the need to culture the contact lens.

		for case 4 would you be able to initiate a steroid once epi defect healed to prevent scarring? Or would you not due to infiltrate being in the periphery?	This is a great question. Once the epithelium healed, I could have considered a steroid, and frequently do so for straightforward cases. For example, the other CLPU case was a typical presentation due to its round shape, peripheral location, and low level of pain, and I prescribed neo/poly/dex. In Case 4, the etiology was not as clear cut. That patient had a star shaped infiltrate, more severe pain, and had been on a steroid. Prescribing a steroid can worsen conditions, especially HSVK, which I was concerned about with the unusual shape of the infiltrate. If this infiltrate was in the visual axis, I would have more concern for scarring and would have considered a steroid upon the epithelium closing, with very close follow up.
		also for this RCE patient, would you wait for the flourescein to drain as much as possible before putting the bandage CL on? To what extent would the flourescein be able to drain before you put on the BCL?	Thanks for this great question. By the time I was putting the BCL on, the fluorescein had already drained. I find that is typically the case, that by the time you've talked to the patient about the dx & tx and gotten your BCL ready, fluorescein is not a concern. If a little fluorescein does get into the lens, it is not problematic but for cosmesis.
		CASE 5: is this pt a candidate for corneal transplant?	Thank you for the question. Yes, when the cornea is sterile and the inflammation has resolved, a corneal transplant would be an option for the patient's visual recovery.
		For peripheral ulcers related to CL overwear do you tend to wait to see epi healing before applying steroids/combo drops	This is a great question. I manage that decision on a case by case basis. One patient I treated had a straightforward CLPU due to its round shape, peripheral location, and low level of pain, and I prescribed antibiotic/steroid combo. I find this to be the most common presentation and treatment. The other CLPU patient was not as clear cut. That patient had a star shaped infiltrate, more severe pain, and had been on a steroid. Prescribing a steroid can worsen conditions, especially HSVK, which I was concerned about with the unusual shape of the infiltrate. I prescribed her an antibiotic initially,

			since I was less confident of the etiology of the infiltrates.
		I was actually wondering about your career path. My undergraduate degree was in honours chemistry where I also did some work in a nano-materials laboratory. What was your path like in going from your optometric clinical education to research and development?	Thank you for asking! Following my OD, I completed a residency in cornea and contact lenses. My intention was to either join another Doctor's practice leading to ownership and build CL as a specialty, OR work with a corneal surgeon and manage contact lenses for those irregular corneas. I had not even considered R&D. I accepted a private practice opportunity in Jacksonville, FL where I hoped to buy in after a few years. That practice did not end up working out, but during my time there I developed a relationship with the JJV R&D department, also in Jacksonville. This relationship was built on our mutual interest in contact lens specificities, as well as support for philanthropic eyecare. When an opening arose for a Research Optometrist at JJV, I could not turn down the opportunity to develop the next new CL! Even though my career path was not as I planned, I couldn't be happier with where optometry has taken me. My advice is to keep making connections, as you have here and also don't be afraid to let your nerd flag fly!
1:00 – 1:50 pm	**Meredith Bishop, OD, MS, FAAO** **Contact Lens Care and Contamination**	could a solution be a cause of lens tightening and being difficult to remove or would you consider that more of a fitting issue?	Thanks for the question. Lens tightness and difficulty to remove are often seen later in the day after hours of wear, when solution impact would be minimal. It would be more likely that a lens tightening and being difficult to remove would be due to the lens material/modulus, a fitting issue, or a dryness issue.
		Isn't there a risk of the case being recontaminated when you allow it to air dry (since it is often left in the bathroom to dry)?	This is a great question, thank you. I didn't go into this in detail during the presentation due to time constraints, however publications have offered some guidance on how to air-dry the case. A 2010 publication by Wu et al, found that the contact lens case

			positioned face up to air-dry had a significantly higher contamination rate compared to cases air-dried face down. While more studies are needed, the current guidance is usually in agreement that the lens case should be air-dried face down (on a clean tissue) to try to reduce contamination/recontamination of the case.
		do you switch the solution bottle as often as the case (every 2 weeks) or longer?	Good question, thank you. While the solution tip does have the ability to be contaminated, if used and closed properly the preservative(s) in the solution should reduce the risk of solution contamination. I would recommend following the manufactures instructions about how often to discard the solution bottle.
2:00 – 3:50 pm	**Chris Freeman, OD, FAAO, David Lampariello, OD, FAAO & Brian Schwam, MD Refractive Surgery Case Discussions – Part I & II**	If the patient is older, would it be better if we consider LASIk over PRK because his cornea should be thicker?	All questions were addressed live, please refer to the recorded session.
		Would SMILE be an option ?	All questions were addressed live, please refer to the recorded session.
		Can you define angle Kappa?	All questions were addressed live and refer to the recorded session.
		What's the risk of pupillary block for phakic IOL ?	All questions were addressed live, please refer to the recorded session.
		do patients with phakic IOL's have difficulty with halos in dim lighting, due to change in pupil size? Is there an ideal pupil size for ICLs?	All questions were addressed live, please refer to the recorded session.
		Can the IOL rub against the poster portion of the iris causing pds/pdg	All questions were addressed live, please refer to the recorded session.
		What about endothelial cell loss with phakic IOL?	All questions were addressed live, please refer to the recorded session.
		What is the recovery time and post-operative care like for patient that have undergone a Phakic IOL?	All questions were addressed live, please refer to the recorded session.
		when condering pachs, do you use central thickness or minimal thickness?	All questions were addressed live, please refer to the recorded session.

SOCCEP Q/A
Thursday, April 16

		Sorry I missed the importance of white to white in refractive or cataract surgery. Do you mind repeating it's importance?	All questions were addressed live, please refer to the recorded session.
4:00 – 4:50 pm	**Caroline Blackie, OD, PhD, FAAO** **Cool Things That You May or May Not Know About the Ocular Surface**	Do you evaluate the lid seal with the transilluminator while viewing through a slit lamp, or is it generally visble with the naked eye?	With the naked eye!
		Could I get more information on the articles Dr. Blackie mentioned earlier.	Here are the references for you: Enjoy! Pult H, Korb DR, Blackie CA, Knop E, Marx E. About vital staining of the eye and eyelids. I. The anatomy, physiology, and pathology of the eyelid margins and the lacrimal puncta by E. Marx. 1924. Optom Vis Sci. 2010;87(10):718–724. doi:10.1097/OPX.0b013e3181f3217e Blackie CA, Korb DR. A novel lid seal evaluation: the Korb-Blackie light test. Eye Contact Lens. 2015;41(2):98–100. doi:10.1097/ICL.0000000000000072 Pult H, Korb DR, Murphy PJ, Riede-Pult BH, Blackie C. A new model of central lid margin apposition and tear film mixing in spontaneous blinking. Cont Lens Anterior Eye. 2015;38(3):173–180. doi:10.1016/j.clae.2015.01.012 Korb DR, Blackie CA. Debridement-scaling: a new procedure that increases Meibomian gland function and reduces dry eye symptoms. Cornea. 2013;32(12):1554–1557. doi:10.1097/ICO.0b013e3182a73843 Korb DR, Blackie CA, McNally EN. Evidence suggesting that the keratinized portions of the upper and lower lid margins do not make complete contact during deliberate blinking. Cornea. 2013;32(4):491–495. doi:10.1097/ICO.0b013e31826a1e6f
5:00 – 5:50 PM	**Kurt Moody, OD, FAAO** **OSD in Clinical Practice: Case Reviews**	No Questions	

SOCCEP Q/A
Thursday, April 16

SOCCEP Q/A
Thursday, April 23

Time	Session Details	Question	Answer
10:00 – 10:50 am	**Sondra Black, OD, FAAO** **Role of the OD in the Era of Refractive Cataract Surgery**	How are you getting these younger patients qualified for cataract surgery under insurance? Or is it considered "refractive lens exchange?"	Age isn't the issue for coverage. It is whether or not they have a cataract and if they are exhibiting visual symptoms that is criteria. For those that are just doing for refractive purposes then it is a refractive lens exchange
		Out of curiosity, how old were you when you had cataract/RLE surgery and what lenses did you choose for yourself?	I was 60/61 (OD/OS) and i have a Symfony EDOF lens in my eyes
		How do LRI and Arcuate incisions compare to RK? Are these people seeing complications years down the road like RK patients do?	No. RK would weaken the cornea as they were extremely deep incisions. LRI's and AI do not affect the corneal stability
		What kind of results are you seeing with light adjustable lenses?	I haven't had any personal experience with them. I do hear good things although the biggest issue that I have heard is the need to wear UV protection continually for a couple weeks post-surgery and pre-treatment. Patient compliance is a key piece here
11:00 – 12:50 PM	**David Murakami, OD, MPH, FAAO** **MGD and Dry Eye & Identify MGD & Treat It**	Is there any data on differences of dry eye exacerbation between LASIK and chronic contact lens wear (with good compliance)?	I am not aware of any head to head comparative studies on the effects that refractive surgery vs. contact lenses can have in exacerbating dry eye signs/symptoms. Each independently has been extensively demonstrated in the literature, as mentioned in the lecture, to not only result in greater dry eye symptoms, but also increase the severity of MGD. And, as a reminder, many publications have now made the strong recommendation to screen for MGD/ocular surface disease (i.e. take a 'proactive approach') especially for new contact lens wearers or patients interested in refractive surgery. These are high risk populations with a high prevalence of MGD. We now have the clinical data and tools/resources to support early MGD screening. These topics are covered extensively in the TFOS DEWS II report Craig JP, Nelson JD, Azar DT, et al. TFOS

			DEWS II Report Executive Summary. Ocul Surf. 2017;15(4):802-812. doi:10.1016/j.jtos.2017.08.003
		When assessing MGD function, do you apply pressure to both upper AND lower lids?	When using a standardized tool to measure function (e.g. MGE), what is commonly and routinely performed, is to just measure lower eyelids. This will give the clinician an idea as to whether there is obstruction of the glands; typically, in cases of MGD, we would expect it to be a bilateral condition that has the potential to affect any meibomian gland present. However, if after assessing MG structure, you determine that only upper eyelid MGs remain, you could you apply the MGE to the upper eyelid – however, the standardized pressure that it exerts may be less consistent as the upper lid requires a slight eversion to adequately view. Korb DR, Blackie CA. Meibomian gland diagnostic expressibility: correlation with dry eye symptoms and gland location. Cornea. 2008;27(10):1142-1147. doi:10.1097/ICO.0b013e3181814cff
1:00 – 2:50 pm	**Chris Freeman, OD, FAAO, David Lampariello, OD, FAAO & Brian Schwam, MD** **Refractive Surgery Case Discussions – Part I & II**	Would you still consider CXL if pt has scarring?	All questions were addressed live, please refer to the recorded session.
		if BCVA is 20/70, intacts may or may not increase VA, what are the thoughts on trying scleral lenses prior to doing intacs but post CXL if there is progression	All questions were addressed live, please refer to the recorded session.
		are there always 2 Intacs used in KC cases, in rotations i was taught 1 intac, but maybe that was only for inferior cone, this was central cone. If it is a central cone, how do intacs work	All questions were addressed live, please refer to the recorded session.
		why can't the residual k s be less than 35D? what are the consequences?	All questions were addressed live, please refer to the recorded session.
		doing Lasik on this eye if phakic IOL did not match refractive error perfectly, would you do it, and how long would you have to wait	All questions were addressed live, please refer to the recorded session.
		question about phakic IOLs, you	All questions were addressed live,

		mentioned concerns regarding loss of endothelial cells over time. What's the average rate of loss and is there an ECC cut off that would tell you it's not a good option?	please refer to the recorded session.
		Would it be safe to assume that with a high myope that there would be less optical minification with a phakic IOL because the correction is inside the eye and closer to the nodal point, relative to corneal refractive surgery? or is it negligible or even a consideration?	All questions were addressed live, please refer to the recorded session.
		Is ortho-K an acceptable option on a post-refractive surgery eye showing signs of ectasia?	All questions were addressed live, please refer to the recorded session.
3:00 – 3:50 pm	**Tawnya Pastuck, OD, FAAO** **Health Economics and Market Access: Evidence-based Value for Cataract Treatment**	No Questions	
4:00 – 4:50 pm	**Xu Cheng, OD, PhD, FAAO** **Clinical Study Designs for Contact Lens Research & Development**	No Questions	
5:00 – 5:50 PM	**Ross Franklin, OD, FAAO** **Tips For Contact Lens Practice**	if you're patient is a high myope (let's say -8.00DS in glasses and a blurry 20/25 -7.50DS in contacts x3years), how do you handle/educate patients that jumping to the next power may be too strong and visually uncomfortable, if they are unsatisfied with the current lower (vertexed) power. do you let them trial the higher power? if they don't like the -8.00DS contact lens power what is your next problem solving step?	Franklin: I would say if they are currently not satisfied, and then you over-refract and the -0.50 extra looks better then give the extra power. If -0.50 D still doesn't make vision good enough, then you need to try a different lens type. Nixon: If the subject is a blurry 20/25, they are probably underminused. From the first 20/20 letter, you can typically give -0.50D to -0.75D without overminusing. I agree with Ross that

			over-refraction and dispensing a trial are great ideas. While overrefraction gets downplayed at times, overrefraction is critical with high Rxs like this because having lens on eye eliminates spec minification (from phoropter) and vertex distance adjustments. Dow: When the visual acuity can be fully corrected in phoropter, but you are not achieving similar results in the contact lens, it is always good to over-refract. If adding power increases acuity, fit the next lens. If your patient doesn't like the higher power due to accommodative issues, consider if that is expected. If presbyopic, this patient would be a good candidate for a multifocal contact lens. If the patient is not presbyopic, consider an accommodative etiology and associated testing like 3-click to blur, NRA/PRA, and wet refraction.
		How do you recommend setting up follow ups for first time wearers and new fits? If a DFE is needed, how do you break up these appointments to keep the patient from getting overwhelmed?	Nixon: If it is a brand new wearer, I will offer to do the application and removal training that day if staff are available. My thoughts are, the subject came in asking to be fit into contact lenses. I would be annoyed if I had prepared and gotten excited for the contact lenses, only to be told I needed to come back next week. I still check both anterior and posterior seg health, but will offer to complete DFE at CL follow-up. Follow-up care will be needed for these patients anyway so the DFE can be worked in relatively easily. Dow: At the initial and any other I&R teaching visits, I do not dilate. I can dilate them at the final follow up.
		what is it like when you meet with a rep? what can we expect? what questions should we ask? how do we reduce the risk of company bias	Nixon: Meeting with Reps shouldn't be stressful. Reps are there to help you, because if you are successful, they are ultimately successful. Use your reps to make sure you have the latest information regarding products/programs/pricing, but ultimately you should focus on what is best for your patients when it comes to prescribing. Test out new products on yourself and with your patients when they become available to

			increase your familiarity. Reps are going to present research that supports their brand or products. They can often give insights about the design of the products and how this translates to their performance. Feel free to ask questions and vet the research to see if was fairly designed and drew reasonable conclusions. If the questions are beyond what the rep is prepared to answer, they should be able to refer you to another point of contact for further information.
		Can you share the last tip Dr. Ross just mentioned at about 5:29 PM please.	Franklin: we are not quite sure which slide I was on at this time, but we think it was about training. Whenever you go into a new practice, take the time to sit in on some training sessions where the technicians teach insertion & removal, as well as instructing on cleaning, hygiene and safety. This will help you to understand if there is any additional information that you need to be providing to the patient. Regardless of how good a job the technician does with training, I think it is always helpful if the patient hears you say "Contact lenses are not supposed to be uncomfortable or make your eye red, so if that happens you have to take them out". So they need to have a pair of wearable glasses and take them wherever they go in case they have to take their contact lenses out.
		How do you tell parents to not hover over their child when training new children that are having anxiety/ helicopter parents ?	Franklin: Tell the parents "We often find that it's best to have as few people in the room as possible so that there's less pressure" Nixon: I would just be proactive about your typical setup before the training. Explain to the parent that you prefer to work 1:1 with the subject for application and removal training. When more people are in the room, especially parents, the kids can get nervous and may have a harder time focusing/following instructions.

			Generally parents are pretty understanding about this. If they really "need" to be in the room, ask them to remain quiet and avoid interrupting the training.

SOCCEP Q/A
Friday, April 24

Time	Session Details	Question	Answer
9:00 – 10:00 am	**Bennett McAllister, OD, FAAO** **Psychological and Social Considerations in Low Vision Rehabilitation**	No Questions	
10:00 – 11:00 am	**Courtney Rafferty, OD, FAAO** **No Sight for Sore Eyes**	your patient had bilateral RNFL thickening? How was this differentiated from bilateral disc edema? (im sorry if you mentioned this earlier	My patient only had one small section of very mild disc edema/ possible RNFL thickening inferonasally in her right eye. I think the confusion may be from her OCT which showed all quadrants in both eyes as "white" which we typically associate as thickening, but for pediatric patients (<18 years old), all sectors on the OCT will appear white because there is no normative database for pediatric patients, which makes detecting very subtle RNFL thickening on OCT even more challenging. If you would like me to send you a link to an article I found that investigated pediatric values for RNFL thickness or have any other questions, my email is courtneyrafferty17@gmail.com, I'm happy to answer any other questions!
11:00 am – 12:00 pm	**Alexis Malkin, OD, FAAO** **Low Vision and Diabetic Retinopathy**	Why hyperopic? Wouldnt the oil stretch the eyeball making it effectively myopic?	This is because of the refractive index of the silicone oil which is higher than the vitreous. It should not be filled to a level that actually stretches the eye.
		What are norms for contrast sensitivity findings?	Normal young/middle age adult: 1.72-1.92 Normal over age 60: 1.52-1.76 Moderate loss: 1.04-1.48 Severe loss: 0.52-1.00 Profound loss: 0.48 and below
		why would there be a hyperopic shift with the silicon oil, isnt it infront of the retina, and would cause a myopic shift?	Same answer as number 1. Here is a citation explaining further: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2789959/

		Is there an aspect of this the Low Vision exam that you would suggest should be commonplace in a primary care exam?	Continuous text reading, contrast sensitivity, and assessment of higher adds. Consider trial frame refraction and low powered magnifiers if available to you
1:00 – 2:00 pm	**Bobby Saenz, OD, MS, FAAO** **Grow your Optometric Practice with Refractive Surgery**	For SMILE, is there any wavefront-guided technology?	There is not any wavefront guided technology with SMILE. However, SMILE does treat on visual axis, rather than pupilary center.
		what about scarring post SMILE, incidence?	If there is a deep scar, then the patient is likely not a candidate for SMILE. However, incidence of scar after SMILE extremely low. I've never seen or heard of a case.
		Is it true there is less ability to re-treat later on with SMILE as compared to LASIK?	If a patient has LASIK and then needs an enhancement, the surgeon can lift the flap and retreat. If a patient has SMILE, the surgeon has two options. Most prefer PRK, but outside the US (and even some in US), can use the laser to turn the lenticule into flap, which basically means that you can do LASIK on top of SMILE. PRK can be used for enhancements after LASIK and SMILE.
		is there more halo/glare with smile compared to lasik?	No difference. https://www.ncbi.nlm.nih.gov/pubmed/29425387/
		How early can you do an ICL? What about pediatric high myopes?	It is on label for 18 years and older. However, they have looked at this and are looking at this. Even spectacle averse special needs children. https://www.sciencedirect.com/science/article/pii/S0002939416305918
		Do ICLs complicate cataract surgery for the patient in the future?	ICLs are great in that they leave all options open when it comes time for cataract surgery.
		what happens in the future when these pts need cataract surgery? is it easy to take the ICL out?	The ICL and cataract can be taken out at the same time.

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		With ICL, once cataracts actually form, do they remove the phakic lens with the ICL to perform CE?	Yes, the ICL and cataract are taken out at the same time and the new IOL is placed. Post-operatively haven't seen as much inflammation as one might imagine. Normal post op drops.
		As the lens thickens with age, will the patient need to have the ICL adjusted?	The ICL is reversible so it can be adjusted/changed if needed. We do a lot of ICLs and have yet to do this, but it is possible.
		Many of these refractive surgeries were geared toward myopes and higher myopes. What would you recommend for high hyperopes, if any?	Great question! Wish we had more time. High hyperopia we really have LASIK or refractive lens exchange. Please consider refractive lens exchange in higher hyperopes earlier in life. 32 year old +7 – refractive lens exchange can be life changing.
		could you share the table with all the refractive surgery options please, age vs power?	Please email me bobbysaenz@gmail.com or send me a message on Instagram @bobbysaenz and I can send that over
2:00 – 3:00 PM	**Nicole Riese, OD, FAAO** **Differential Diagnoses and Treatment of Anterior Scleritis**	Do you put a full drop of phenylephrine in the eye or use a cotton swab on the injected area?	Yes, a full drop in the eye.
		would you niot expect durezol to work reasonably well with a mild scleritis?	I do not believe Durezol has been studied for scleritis. Other topical treatments have been shown not to be effective for scleritis.
		How long do you usually have these patients take the oral NSAID to treat the scleritis?	It varies depending on the severity of the case. You want to treat until signs and symptoms are completely resolved and then typically a little past to prevent a rebound.
3:00 – 4:00	**Identification, Assessment, and Treatment of Unilateral Spatial Inattention**	Can you define what you mean by "rotators" you can send home with patients?	Rotators are prism glasses where the base can be changed to any direction you choose. You can take a 5^ prisms, place them in the frame and rotate them to be up, down, right, or left pending on your needs. They are customizable prism glasses.

SOCCEP Q/A
Friday, April 24

4:00 – 5:00 pm	**Richard Baird, OD, FAAO** **Seeing Spot(s)!**	Dr. Baird mentioned getting in contact with him to learn more about potential job opportunities. Can I get his contact information in order to learn more? My email is clif7056@pacificu.edu	My e-mail is richard.y.baird.mil@mail.mil. My phone number is 661-277-5091. I will also reach out to this student.