

Optimum VA

NAVAO Newsletter

October 2003

President's Report

VA Optometry news.

Its hard for me to believe that this is the last President's Report that I will be writing after 4 tumultuous years as your leader. Rather than give everyone a pep talk, I thought I'd discuss what has happened in the last 4 years and how critical new leadership steps up the plate to work on the issues so important to us in the VA and optometry in general.

It is our goal to hold electronic elections via our website (www.navao.org). Please review the bylaws published on the site and make a decision to lead all of us!

At the time I began as NAVAO president, ABOP was moving through the AOA leadership channels almost as a stealth weapon. We saw that as an illegitimate method to garner board certification and fortunately for the profession, the issue was defeated. But the discussions opened up a legitimate question. What recognition can those who have completed residencies have to ensure that they are recognized for what they are? It has always been my opinion that the expertise that residents obtain especially at the VA gives them advanced competence. But saying it and having it mean something are 2 different things. Over the past 3+ years, we have worked with NBEO to develop an examination for advanced competence **for VA Residents only**. This exam's first administration will be in June 2005 and it is our understanding that Dr. Townsend will require those completing residencies 6/30/05 to take it. This means that those who we recruit in this upcoming cycle!!

Now, while there is naturally a ton of grumbling about the potential costs, rest assured that we are doing everything possible to have some corporate support to underwrite this so that residents can spend as little as possible out of pocket money. I am confident that the pass rate will be so high that the Office of Academic Affiliations' long sought after Outcomes Assessment requirement will be satisfied. NBEO is the premiere testing agency among health professions. Most of organized optometry's opposition is based on their fees but from what those of us who have worked with them have seen, it is not in any way more gouging than the \$20,000-\$30,000 tuition that private schools charge. Costs are high, exams are expensive to devise and certainly it is better to have an expensive but unassailable examination in terms of quality than a less expensive but questionable product. So while I am certainly sympathetic to the plight of the poor resident that has to take the exam, I am confident that this measure of their advanced competence will be worth far more than the residency certificate they now achieve.

Each of you who have completed residencies in the VA (and only the VA) would be wise to consider taking this examination. It most certainly is a vehicle for promotion. Moreover, it is a measure of advanced competence that you know you have!

So while the discussion over fees is legitimate, lets not lose sight of the basic premise: We need a credible outcomes assessment for our residency program and this gives it to us on a silver platter!

Over the past years, NAVAO has established itself as a major stakeholder in the profession as well it should have. We control a great deal of the education of so many future and post graduate optometrists. It is critical that NAVAO present its world view to the profession at large and as such, we've had a voice (albeit not always a well received one) at AOA, AAO, and ASCO. There has been some in our group wanting us to fold our group into the Armed

Forces Optometric Society (AFOS). While one can see certain benefits, its been my opinion that we are civilians and have a somewhat different agenda and different world views on some critical areas. I believe we should work in concert with our AFOS brethren but we need to be a distinct organization as we and only we represent VA Field Optometrists.

Finally, no state of the association report would be complete without addressing our finances. We are in good shape as we head into the Academy Meeting in Dallas. We have been fortunate to be well supported by Pharmacia (now Pfizer) and we've had busy meetings in recent years. Most importantly, we need not raise our due to members already paying other association dues.

I want to take this time to thank all of you for the support you have given me over the past 4 years. I have taken strength from it and your voices were heard! I also want to especially thank our board and all of those who have served NAVAIO in special capacities:

Sharon Atkin, Immediate past president
Tom Golis, Secretary, first term, Treasurer, 2nd term
Paul DeAlba, Vice President...first term
Bob Emery, Newsletter Editor, first term
Rebecca Sterner, Membership Secretary
Mike White, Secretary, 2nd term
Alyon Wasik, Vice President, 2nd term
John Spalding, Newsletter Editor, 2nd term
Anthony Ficarra, Webmaster, 2nd term.

I am reserving my thanks to a special section for 4 who have contributed so much to our organization.

Dawn Pewitt, Meetings Coordinator and Planner

Dawn has done it all! Remember the great dinner meetings the past few years? Dawn worked tirelessly organizing the room, arranging the menus, ensuring everything went just right. Thanks Dawn...its been a real pleasure working with you!

Ken Myers

Ken has provided extremely valuable insight and history of other professions struggles with outcome measurement. He has spent many hours and has traveled to advance this concept on behalf of NAVAIO. Thanks Ken!

Arnie Adler

Arnie is the one who gets the certificates made for those who have done special work for us this year. He has done this as long as I can remember and I just want to make sure we thank him appropriately.

Bob Newcomb

Bob is the one who gets plaques and gifts for honorees at the national meeting. Bob has been retired from the VA for years now but he always will be a VA optometrist! Thanks Bob!

Our meeting this year will be another great affair. Here's the schedule of events:

NAVAO Business meeting, 5:30-6:30pm: Bryan-Beeman Room

NAVAO Reception, 6:00-7:30pm: Reunion Ballroom A

NAVAO Banquet, 7:30-11:00pm: Reunion Ballroom B-C

As has been the custom the past few years, the meeting is fully sponsored and should be a gala event. You should receive an invitation sometime within the next month. I hope to see all of you there.

The winds of autumn are blowing now, my time as your leader will soon be done. Please consider working within the organization in any capacity. Those of us who have been there ahead of you can mentor and help...but we need you! I bid you adieu though we'll see each other one more time in Dallas. Thanks for everything and I look forward to the future together.

- Jerry

Clinical Pearls

Highlights from recent publications.

COST CONSIDERATIONS FOR GLAUCOMA

To determine the calculated daily patient cost (cost minimization) of medical glaucoma therapy and review cost trends. The actual volume of various glaucoma medications or glaucoma medications with redesigned bottles was determined for most commercially available sizes of the tested products. The drops per milliliter based on the actual volume and the daily costs of the dosage schedules recommended by the manufacturers were compared. The cost of each bottle of medication was determined from the average wholesale price (AWP) in the United States. The generic timolol products (range, \$0.38– \$0.46 per day) were similar on a cost per day basis vs Betimol, and Timoptic. Betagan, Betoptic S and Ocupress ranged from \$0.88 to \$1.11 per day. The mean cost per day for the topical carbonic anhydrase inhibitors Azopt \$1.33 per day and Trusopt \$1.05 per day differed from Cosopt \$1.04 per day was less than the cost of separate bottles of a topical carbonic anhydrase inhibitor and a β -blocker. The selective α -2 agonist brimonidine 0.15% with Purite twice daily was \$1.29 per day. The prostaglandin analogs were comparably priced with Lumigan \$0.95 per day, Xalatan \$1.25 per day, Travatan \$1.01 per day, and Rescula \$0.90 per day.

Fiscella RG, Green A, Patuszynski DH, Wilensky J. AJO July 2003: 18-25.

DRY EYES IN WOMEN

The prevalence of DES increased with age, from 5.7% among women < 50 years old to 9.8% among women aged = 75 years old. The age-adjusted prevalence of DES was 7.8%, or 3.23 million women aged = 50 in the US. There were no significant differences by income, but more educated women were less likely to have DES. Women from the South had the highest prevalence of DES, though the magnitude of geographic differences was modest.

Schaumberg DA, Sullivan DA, Buring JE, Dana MR. AJO Aug 2003: 318-326.

INTRAVITREAL KENALOG FOR MACULAR EDEMA AFTER CRVO

This study included 10 eyes of nine patients with perfused central retinal vein occlusion with visual acuity of 20/50 or worse. Following baseline evaluation, including best-corrected visual acuity, intraocular pressure (IOP), fluorescein angiography, and volumetric optical coherence tomography (VOCT), triamcinolone acetate (4 mg in 0.1 ml) was injected into the vitreous cavity. Mean duration from the time of diagnosis to the intravitreal injection was 15.4 months. All 10 eyes demonstrated biomicroscopic improvement in cystoid macular edema. Mean best-

corrected visual acuity improved from 58 letters at baseline to 78 letters at last follow-up (average, 4.8 months). Six eyes (60%) were =20/50. There were no significant complications. Three eyes (30%) without previous history of glaucoma required initiation of topical aqueous suppressant therapy for IOP elevation at last follow-up. One eye with a previous history of open-angle glaucoma required a trabeculectomy.

Park CH, Jaffe GJ, Fekrat S. AJO, Sept 2003: 419-425.

RISK PROFILES FOR MS DEVELOPMENT: OPTIC NEURITIS TREATMENT TRIAL AT 10 YRS

The authors conclude that the 10-year risk of multiple sclerosis following an initial episode of acute optic neuritis is significantly higher if there is a single brain MRI lesion; higher numbers of lesions do not appreciably increase that risk. However, even when brain lesions are seen on MRI, more than 40% of the patients will not develop clinical multiple sclerosis after 10 years. In the absence of MRI lesions, certain demographic and clinical features seem to predict a very low likelihood of developing multiple sclerosis. This natural history information is a critical input for estimating a patient's 10-year multiple sclerosis risk and for weighing the benefit of initiating prophylactic treatment at the time of optic neuritis or other initial demyelinating events in the central nervous system.

Optic Neuritis Study Group. Archives July 2003: 944-949.

SLT AS PRIMARY TREATMENT FOR COAG

Forty-five eyes of 31 patients with open-angle glaucoma or IOP ≥ 23 mm Hg on 2 consecutive measurements underwent selective laser trabeculoplasty as primary treatment. The IOP was measured 1 hour, 1 day, 1 week, and 1, 3, 6, 12, 15, and 18 months postoperatively. During the follow-up period, patients were treated with topical antiglaucoma medications as required. Mean IOP decreased by 7.7 (30%). Only 2 eyes (4%) did not respond to selective laser trabeculoplasty, and 3 eyes (7%) required topical medications to control their IOP at the end of the follow-up period. Forty eyes (89%) had a decrease of 5 mm Hg or more. Visual acuity, visual fields, and gonioscopic findings remained unchanged. Complications included conjunctival redness and injection within 1 day postoperatively in 30 eyes (67%). One hour after selective laser trabeculoplasty, an increase in IOP of more than 5 mm Hg was detected in 5 eyes (11%).

Melamed S, Ben Simon GJ, Levkovitch-Verbin H. Archives July 2003: 957-960.

PLAQUENIL AND IRREVERSIBLE RETINAL TOXICITY

335 Greek patients with RA and 191 with SLE treated with HCQ, 400 of whom had completed at least 6 years of treatment were evaluated. No HCQ retinal toxicity was noted in any of the 526 patients during the first 6 years of treatment. Two (3.4%) of the first 58 long-term (>6 years) treated patients developed HCQ-related maculopathy at 8 and 6.5 years of treatment, despite regular ophthalmologic evaluation. On follow-up 7 and 9 years after cessation of HCQ treatment, both patients had stable eye disease. No HCQ retinal toxicity was observed in the subsequent 342 patients who were treated for >6 years. Overall, the incidence of HCQ-related retinopathy in 400 patients who were treated with recommended dosages of the drug for a mean of 8.7 years was reduced to 0.5%. The authors conclude that after a baseline ophthalmic examination to confirm the absence of preexisting fundus pathology, patients with normal renal function may receive HCQ at a maximal daily dosage of 6.5 mg/kg and continue safely for 6 years. However, annual screening is recommended in patients who have taken the drug, even in recommended doses, for >6 years.

Mavrikakis I, Sfrikakis PP, Mavrikakis E, Rougas K, et al. Ophthalmology July 2003: 1321-1326.

COSOPT VS XALATAN

Thirty-three patients completed the study. On the last day of treatment, the mean diurnal intraocular pressure for latanoprost was 15.9 mm Hg and for Cosopt was 15.3 ± 2.0 mmHg ($P = 0.05$). Individual time points for intraocular pressure were not statistically different between groups except at the 10:00 PM time point, when the mean for Cosopt was 14.6 mmHg and for latanoprost was 16.6 mmHg ($P < 0.006$). Eighteen patients overall preferred latanoprost versus 2 patients for the fixed combination, generally because of the greater convenience of once daily dosing. Adverse events were not significantly different between groups except that a bitter taste was found more frequently with Cosopt ($n = 9$) than with latanoprost ($n = 0$; $P = 0.009$). Despite screening to exclude intolerance to β -blockers, a single patient had to discontinue the TDFC because of new-onset asthma.

Konstas AGP, Papapanos P, Tersis I, Houliara D, et al. *Ophthalmology* July 2003: 1357-1360.

APPEARANCE AND 10 YEAR INCIDENCE OF AMD

4926 adults (range, 43–86 years of age at baseline) living in Beaver Dam, Wisconsin, was studied at baseline (1988–1990); of these, 3684 and 2764 subjects, respectively, participated in 5-year and 10-year follow-up examinations. When controlling for age and gender, people with brown eyes were significantly more likely to develop soft indistinct drusen than were people with blue eyes. However, people with brown eyes were significantly less likely to develop retinal pigment epithelial depigmentation than were people with blue eyes. When compared with persons with blond hair, persons with brown hair were at decreased risk of developing pigmentary. Iris color, hair color, and skin sun sensitivity were not associated with the development of late ARM. The authors conclude that iris color and hair color were found to be associated with the 10-year incidence of pigmentary abnormalities. Iris color seems to be inconsistently related to the 10-year incidence of early ARM lesions and the progression of ARM.

Tomany SC, Klein R, Klein BEK. *Ophthalmology* August 2003: 1526-1533.

REITER'S SYNDROME

Twenty-five patients (20 male and 5 female) diagnosed with RS, with a mean age at presentation to our service of 37 years, were studied. The mean follow-up was 48.5 months. Eighty-five percent of patients tested were positive for human leukocyte antigen B27. Sixty-four percent of patients had a positive family history. All patients had oligoarthritis and enthesitis, most commonly affecting the back (56%), Achilles tendon (52%), and sacroiliac joint (24%). Eighty percent had a history of infection, most frequently urethritis (68%). Forty-four percent had a history of mucocutaneous lesions. All patients demonstrated ocular involvement at the time of diagnosis (68% with unilateral and 32% with bilateral disease), 84% had evidence of uveitis, 3% had scleritis, 2% had conjunctivitis, and 1% had pars planitis and iridocyclitis. Systemic treatment for ocular inflammation was initiated in all patients. Ninety-six percent were treated with nonsteroidal anti-inflammatory agents. Eighty-eight percent were treated with corticosteroids, 64% requiring systemic prednisone. Immunosuppressive therapy was initiated in 52% of patients, with all receiving methotrexate. Seven patients required more than one immunosuppressive agent. The authors conclude that Reiter's syndrome may be associated with chronic recurrent ocular inflammation. Systemic therapy (including immunosuppressive treatment) typically is required to control the ocular inflammation and to prevent progressive visual loss.

Kiss S, Letko E, Qamruddin S, Baltatzis S, et al. *Ophthalmology* September 2003: 1764-1769.

Original Articles

NEW SCREENING TARGET FOR OCULAR DISEASE

Author: Steven Mordukowitz, OD, FAAO, Bronx VAMC

ABSTRACT:

The Teich Target was developed and found to be an effective screening tool for AIDS patients to monitor for the development of scotomas or metamorphopsia secondary to CMV retinitis. In our eye clinic, we studied the feasibility of utilizing the Teich Target as a screening device for all new patients scheduled for routine eye examinations.

Results of our investigation yielded a substantial proportion of asymptomatic patients (18%) reporting abnormalities on the Teich Target which correlated with significant ocular pathology. The Teich Target, with its wider 45 degree field and central fixation-lock targets, may be a more suitable device to test for ocular disease, especially outside the central 20 degree field screened by the Amsler Grid.

OBJECTIVES:

To determine the efficacy of the Teich Target as a screening device for retinal or optic nerve disease affecting vision.

INTRODUCTION:

The Teich Target, (see Figure 1) developed by Dr. Steven Teich, a retinal specialist, is a screening chart used to test the central 45 degrees of the Visual Field for defects. It was originally developed to be used as a self-screening device for patients suspected of developing CMV retinitis.

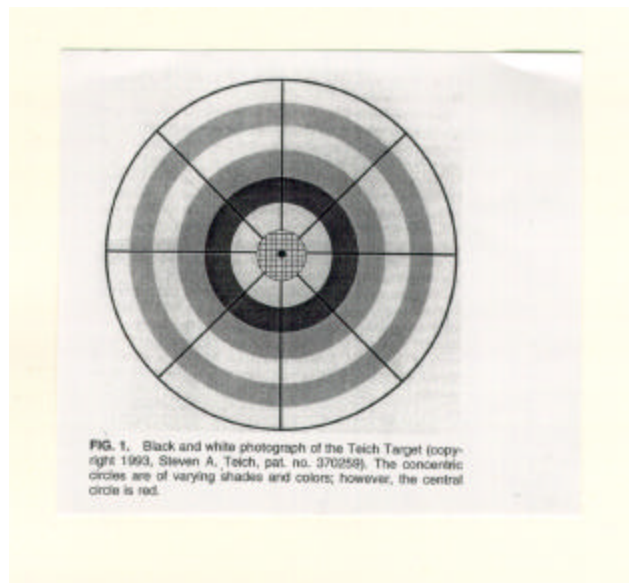


Figure 1

The Amsler grid has been the most widely used method for self-monitoring in the detection of macular disease. The major disadvantage of the Amsler grid is its inability to test beyond the central 20 degrees (10 degrees on each side of fixation). Therefore, certain diseases present at or near the optic nerve head (which is approximately 15 degrees from fixation) may go undetected with this method.

The Teich Target enables patient self-monitoring with a larger visual field covering 45 degrees (22.5 degrees on each side of fixation). The Teich Target consists of a central fixation dot surrounded by a red circle that contains a grid. Surrounding this central red circle are a series of concentric circles of varying colors and

shades. Radial lines emanate from this central red circle extending outwards towards the periphery. These radial lines serve as a “fixation lock” for patients with large central scotomas and aid in detecting enlargement of scotomas. The more complex design of the Teich Target may also reduce the perceptual “filling-in” of scotomas that occurs with the Amsler Grid, a common cause of false negatives.

METHODS:

Seventy-four patients, not previously seen by the examiner, with no known pre-existing ocular disease, were screened with the Teich Target after initial VA measurements for any distortion or scotomas. All patients either presented voluntarily for their annual eye examination, or were referred by their primary care practitioner for routine eye examinations in compliance with the policy for all new patients in the VA health care system. All patients were seen in the eye clinic of the Bronx VAMC, which serves a population of mostly geriatric veterans. Seventy-three males and one female were screened from July 26, 2001 through August 30, 2002 by the same examiner. The ages of our patients ranged from 23 to 88 years, with a mean age of 60.2 years.

Teich Target screenings were performed with either the patient’s habitual reading glasses or with their reading prescription in a trial frame. All Teich Target screenings were performed prior to ophthalmoscopy, biomicroscopy, tonometry or any use of topical pharmaceutical agents.

All patients received full ophthalmic evaluations including applanation tonometry, dilated fundus examinations with binocular indirect ophthalmoscopy and slit lamp biomicroscopy. The presence or absence of retina or optic nerve disease was noted, with special attention to the macular area. The presence or absence of abnormalities on the Teich Target were then correlated with the clinical findings of macular or optic nerve disease.

Medical history of the patients in our study ranged from a variety of medical conditions reflective of a population of aging veterans. These included hypertension, diabetes mellitus, sarcoidosis, osteoarthritis, coronary artery and HIV disease, prostate cancer and alcohol abuse.

RESULTS:

Of the 74 patients screened for ocular disease, four (5%) were symptomatic with complaints of a scotoma or distortion prior to ocular examination. Fifteen (20%) patients detected abnormalities on the Teich Target. Thirteen of these patients (87%) had true positive results with ocular pathology consistent with these findings. Therefore, 18% of the screened population had previously unknown vision threatening disease detected by the Teich Target. In addition, there were two (3%) patients who gave false positive results with no detectable ocular disease to explain these findings. Four (5%) patients with ocular disease (confirmed by ophthalmic examination) gave false negative responses. Overall, 76% of patients with significant posterior pole disease were detected by the Teich Target.

Sensitivity and Specificity of Teich Target:

| | <u>w/ disease</u> | <u>w/o disease</u> |
|----------|-------------------|--------------------|
| Positive | 13 | 2 |
| Negative | 4 | 55 |

Sensitivity = 74%

Specificity = 96%

(chi-square test = 43.21, equals p-value less than 0.05)

CONCLUSIONS:

The Teich Target, with its wider 45 degree central visual field, can be used as an effective screening device for asymptomatic patients seeking routine ophthalmic evaluation. In addition, it can also be utilized by other primary care physicians, nurses and allied health care practitioners as an aid for determining which patients desiring routine ophthalmic evaluation require immediate referral for ocular examination, and which can be deferred for evaluation at a later date.

REFERENCES;

- Dhillon B. "The management of CMV retinitis in AIDS." Br J. Oph 78:66-69, 1994.
Jabs DA, Enger C, Bartlett JG. "CMV retinitis and AIDS." Arch Oph 107:75-80, 1989.
Hartstein ME, Chin PK, "CMV retinitis screening in an urban population." Invest Oph Vis Sci 35(5):1893, 1994.
Teich S., Saltzman B., "Evaluation of a New Self-Screening chart for Cytomegalovirus Retinitis in patients with AIDS", Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology. Vol 13, No. 4, 336-342, 1996.

Copies of the Teich Target can be obtained by contacting:

Dr. Steven Teich, Retina Specialist
20 E. 68th St –Suite 1A
New York, NY 10021

Case Reports and Photo Essays

No information was submitted.

Thoroughbreds

Kudos to the lecturers / writers within the VA Optometry Service.

Lectured:

No information was submitted.

Published:

Bohlman, Hal. Perforated Punctal Plug in the Treatment of Partial Punctal Stenosis. [Optometry](#). August 2003.

Fingeret, Murray. New Horizons in Glaucoma. [Review of Optometry](#). July 2003.

Pian Debi, Ferrucci Steven, Anderson Sheila F. Paramacular Coloboma. [Optometry and Vision Science](#). August 2003.

Zalatimo, Nadia (2nd co-author). Hepatitis C: A Review of Diagnosis, Management, and Ocular Complications from Treatment. [Optometry](#). August 2003.

Calendar

Important dates to remember.

October 27-28, 2003

Fourth Annual VISN 8 Continuing Education Conference, Ft. Lauderdale, FL
9 Hours of COPE Approved and Transcript Quality CE. Contact: joseph.molinari@med.va.gov

November 15-18, 2003

American Academy of Ophthalmology, Anaheim, CA, www.aao.org/annual_meeting/

December 4-8, 2003

American Academy of Optometry, Dallas, TX, www.aaopt.org

Internet Links

Suggested web sites.

JOURNALS

Archives of Ophthalmology, <http://archophth.ama-assn.org/>
American Journal of Ophthalmology, <http://www.ajo.com/>
British Journal of Ophthalmology, <http://bjo.bmjournals.com/contents-by-date.0.shtml>
Clinical and Experimental Optometry, <http://www.optometrists.asn.au/ceo/ceo.html>
Ocular Surgery News, <http://www.osnsupersite.com/>
Ophthalmology, <http://www.aaojournal.org/>
Primary Care Optometry News, <http://www.pconsupersite.com/>
Review of Optometry, <http://www.revoptom.com/>
Review of Ophthalmology, <http://www.revophth.com/>

MISCELLANEOUS

Medscape Ophthalmology, <http://www.medscape.com/ophthalmologyhome>
Ophthoguide, <http://www.ophthoguide.com/ophtho/>
OphthoLinx, <http://www.ophtholinx.com/>

ORGANIZATIONS

American Academy of Optometry (AAO), <http://www.aaopt.org/>
American Academy of Ophthalmology, <http://www.aao.org/>
American Optometric Association (AOA), <http://www.aoanet.org/>
National Association of VA Optometrists (NAVAO), <http://www.navao.org/>
National Board of Examiners in Optometry (NBEO), <http://www.optometry.org/>
National Eye Institute (NEI), <http://www.nei.nih.gov/>
Optometry Residency Matching Service (ORMS), <http://www.optometryresident.org/>
VA Optometry Service, <http://vaww.va.gov/optometry/>

EDUCATIONAL

Bascom Palmer Eye Institute, http://www.bpei.med.miami.edu/site/info/info_gr.asp
Massachusetts Eye and Ear Infirmary, <http://www.djo.harvard.edu/GRhome.html>
Optcom Grand Rounds, <http://www.optcom.com/dgr.html>
Oxford University, <http://www.mrcophth.com/oxfordpd.htm>
Wilmer Eye Institute, <http://www.wilmer.jhu.edu/training/profound/ROUNDS.HTM>
Common Cases and MCQs, <http://www.mrcophth.com/commonshortcasesindex1.html>
Eye Atlas, <http://www.eyeatlas.com/>

Miscellaneous Information

- **NAVAO Board Members**

President: Gerald Selvin, O.D., gerald.selvin@med.va.gov
Past-President: Sharon Atkin, O.D., sharon.atkin@med.va.gov
Vice-President: Alyon Wasik, O.D., alyon.wasik@med.va.gov
Secretary: Michael White, O.D., michael.white5@med.va.gov
Treasurer: Thomas Golis, O.D., thomas.golis@med.va.gov
Membership: Rebecca Sterner, O.D., rebecca.sterner@med.va.gov
Newsletter Editor: John Spalding, O.D., john.spalding@med.va.gov

- **Annual NAVAO Membership**

If you know of a colleague who may be interested in joining NAVAO, please have them send \$40 to NAVAO, Attention: Barb Nahlik, 1034 S. Brentwood Suite #300, St. Louis, MO 63117.

- **Estimated Newsletter Publication Dates**

January 15th, deadline for submission December 31st
April 15th, deadline for submission March 31st
July 15th, deadline for submission June 30th
October 15th, deadline for submission September 30th

- **Original Work Guidelines**

-PHOTO ESSAYS AND CASE REPORTS
History, Diagnosis, Treatment, Discussion, References
250 word limit on discussion

- **SUBMIT ALL NEWS/KUDOS/ARTICLES/CALENDAR DATES TO:**

John M. Spalding, OD, FAAO @ john.spalding@med.va.gov