

Optimum VA

NAVAO Newsletter

July 2002

President's Report

VA Optometry news.

Its mid July, we're well into the most intense period of the year in clinics with training programs with new residents beginning 7/1/02. Kudos to Academic Optometry as my personal observation is that this year's crop are the best trained ever!

The big news for all of us in the field is the official sign off of the **VHA Eyecare Handbook**. Great kudos to our Director, **Dr. Townsend** for his excellent and tireless effort in working with all stakeholders so we could have a document everyone could be proud of! Valerie Jarrard has sent an electronic copy to all optometrists in the field so be sure to contact her if you haven't received it.

There has recently been a controversy regarding the "**preferred**" **prostaglandin analogue**. Most of us agree that the more available, the better off the patients are. However, the reality that we are a managed care system and costs must be considered means that not all drugs will be available to all patients if there are reasonable alternatives without compromising care. Because of vigorous input from NAVAO and field optometrists and ophthalmologists, blanket formulary decisions will be muted. That is, in the class of prostaglandin analogues, all companies will have equal chance to bid and the playing field will be level. Because of the strong response from the field, doctors actually taking care of the patients had sufficient input into the decision.

We as a group must have great concern of the potential of a major recruiting problem for ODs out of a residency. I've always taken pride in the elite corps of fellow VA Optometrists. That quality is threatened by our salary structure which needs to be changed such that those out of a residency can consider VA employment and still pay off their students loans. Hopefully, a revised qual standard will allow the VA to offer people out of residencies competitive salaries. This is particularly acute in high cost of living areas which tend to have prohibitive housing costs.

The **Glaucoma Challenge** sponsored by Pharmacia is finished. I will be sharing the entries with those who have agreed to be judges beginning the week of 7/29 and hopefully we'll have a winner declared by 8/31.

Finally, our **Advanced Competency Recognition** proposal for our residents has been finalized. This is a critical area which will allow those optometrists with residency training to be recognized for their Advanced Competence. The time has come and it is my hope that the mechanism will be in place soon.

Have a lovely summer everyone!

- Jerry

Clinical Pearls

Highlights from recent publications.

MACULAR TRANSLOCATION IN AMD

This study consisted of a standardized surgical procedure on a series of 90 consecutive patients and follow-up examinations at fixed intervals for 12 months. All patients in this study had experienced recent visual loss resulting from subfoveal CNV caused by AMD. Twenty-six patients had major macular subretinal hemorrhage, 39 patients had occult subfoveal CNV, and 25 patients had classic subfoveal CNV. Visual acuity increased by 15 or more letters in 24 patients, remained stable in 37 patients, and deteriorated by 15 or more letters in 29 patients at 12 months postoperatively. A secondary procedure was necessary in 17 patients because of severe complications; proliferative vitreoretinopathy was observed in 17 eyes, macular pucker in 5 eyes, and macular hole in 1 patient.

Aisenbrey S et al. Arch Ophthalmol. April 2002;120:451-459

BULL'S EYE MACULOPATHY

Forty-seven patients, were distributed into 3 distinct groups. Group 1 showed a distinct ring of increased autofluorescence surrounding an area of decreased autofluorescence. In group 2, the ring of increased autofluorescence was not present. Group 3 displayed a speckled appearance within the affected area. All patients had evidence of central sparing in an area of centrally increased autofluorescence. There was significant correlation with the age of onset, visual acuity, and duration of disease. 28 patients had macular dysfunction only, 14 had cone-rod dystrophy, 3 had rod-cone dystrophy, and only 2 (monozygotic twins) had cone dystrophy.

Kurz-Levin MM, et al. Arch Ophthalmol. May 2002;120:567-575

SLEEP APNEA AND NAION

Twelve (71%) of 17 patients with NAION had sleep apnea syndrome. This association may explain why approximately 75% of all patients with NAION discover visual loss on first awakening or when they first use vision critically after sleeping. Our findings indicate that SAS may play an important role in the pathogenesis of NAION.

Mojon DS et al. Arch Ophthalmol. May 2002;120:601-605

BENEFITS OF LOWERING IOP IN OCULAR HYPERTENSION

1636 participants with no evidence of glaucomatous damage and elevated IOP were randomized to either observation or treatment with commercially available topical ocular hypotensive medication. At 60 months, the cumulative probability of developing POAG was 4.4% in the medication group and 9.5% in the observation group. Although this does not imply that all patients with borderline or elevated IOP should receive medication, clinicians should consider initiating treatment for individuals with ocular hypertension who are at moderate or high risk for developing POAG.

Kass MA, et al. Arch Ophthalmol. June 2002; 120:701-713

FACTORS PREDICTING ONSET OF GLAUCOMA IN OCULAR HYPERTENSION

Baseline factors that predicted the development of POAG included older age, larger vertical or horizontal cup-disc ratio, higher intraocular pressure, greater pattern standard deviation, and thinner central corneal measurement.

Gordon MO, et al. Arch Ophthalmol. June 2002;120:714-720

AGE-RELATED MACULOPATHY IN TWINS

Five hundred six twin pairs, with a mean age of 62 years, were examined. The overall prevalence of ARM was 14.6%. Modeling confirmed a genetic effect for phenotypes of ARM, soft drusen, pigmentary changes, and 20 hard drusen. The heritability of ARM was estimated as 45%.

Hammond CJ, et al. Ophthalmology April 2002; 109: 730-736

VISUAL IMPAIRMENT IN HISPANICS LIVING IN THE U.S.

4774 Hispanic residents in Southern Arizona aged 40 years and older were evaluated. The leading cause of visual impairment was cataract (42%), followed by age-related macular degeneration (15%), and diabetic retinopathy (13%). Among 14 people who were bilaterally blind, open-angle glaucoma was the leading cause.

Rodriguez J, et al. Ophthalmology April 2002; 109: 737-743

VF PROGRESSION AFTER TRABECULECTOMY IN NTG PATIENTS

Twenty-three patients with NTG who had significant progression of visual field damage preoperatively underwent trabeculectomy using antimetabolites. IOP significantly decreased from 16.2 ± 1.8 mmHg preoperatively to approximately 11 mmHg during the postoperative follow-up period. Trabeculectomy was statistically associated with slowing further progression of visual field damage in patients with progressive NTG. The progression, however, did not completely stop over the 6-year postoperative follow-up period.

Shigeeda T, et al. Ophthalmology April 2002; 109: 766-770

OCULAR TOXOPLASMOSIS

One hundred fifty-four consecutive patients with active lesions of OT (first attack and/or recurrence) were evaluated. Primary retinal lesions were observed in 28% and a combination of active lesions and old retinochoroidal scars in 72% of the patients at first presentation to the ophthalmologist. Mean age at first presentation with an active OT lesion was 29.5 years. Recurrences, which developed in 79% of all patients followed for more than 5 years, were located predominantly in previously affected eyes (with old scars) in contrast to the sporadic cases of recurrence in the healthy contralateral eye. Standard short-term therapeutic modalities had no effect on visual outcome or future recurrence rates. Legal blindness in one or both eyes was confirmed for 24% of the patients. Risk factors for visual loss included congenital infection, OT manifesting during the acute phase of systemic infection, central location and/or extensive retinal lesions, and the administration of corticosteroids without a shield of antiparasitic drugs.

Bosch-Driessen LEH, et al. Ophthalmology May 2002; 109: 869-878

STEROIDS AND BACTERIAL KERATITIS

Publications from 1950 to 2000 that evaluated the effect of corticosteroids on bacterial keratitis in animal experiments, case reports and series, case-comparison and cohort studies, and clinical trials were systematically reviewed. The use of a topical corticosteroid before the diagnosis of bacterial keratitis significantly predisposed to ulcerative keratitis in eyes with preexisting corneal disease. Once microbial keratitis occurred, prior corticosteroid use significantly increased the odds of antibiotic treatment failure or other infectious complications. However, the effect of a topical corticosteroid with antibiotics after the onset of bacterial keratitis was unclear. Experimental models suggested likely advantages, but clinical studies did not show a significant effect of topical corticosteroid therapy on the outcome of bacterial keratitis.

Wilhelmus KM. Ophthalmology May 2002; 109: 835-842

LATE ONSET BLEB-RELATED ENDOPHTHALMITIS

An antifibrotic agent was used in 40 of the 49 eyes identified, including mitomycin-C in 33 and 5-fluorouracil (5-FU) in 7 patients. The mean interval between the initial filtering surgery and endophthalmitis diagnosis was 5.0 years. Potential risk factors and clinical features among the study population included history of bleb leak, bleb manipulations, needling, compression sutures, laser suture lysis, bleb revision, and autologous blood injection, bleb defects, inferior bleb location, and nasolacrimal duct obstruction. The most common causative organisms were *Streptococcus* and *Staphylococcus*. Eleven patients eventually underwent enucleation or evisceration secondary to pain and/or poor vision.

Song A. Ophthalmology May 2002; 109: 985-991

TRAVOPROST 0.004% VERSUS TIMOLOL 0.5%

Six hundred five patients with open-angle glaucoma or ocular hypertension with an 8 AM IOP between 24 to 36 mmHg in at least one eye (the same eye) at two eligibility visits received either travoprost 0.004% (dosed every day), or timolol 0.5% (dosed twice daily). The mean IOP was significantly lower for travoprost compared with timolol. Travoprost was statistically superior to timolol. Hyperemia was experienced at rates of 42.8% for travoprost 0.004%, and 8.9% (18 of 202) for timolol. Iris pigmentation changes were observed in 1.0% of patients receiving travoprost 0.004%.

Fellman RL. Ophthalmology May 2002; 109: 998-1008

FIVE YEAR INCIDENCE OF OAG

A total of 3271 participants aged 40 years and older from Melbourne, Victoria, Australia were evaluated. The overall incidence of definite OAG was 0.5%. The incidence of possible, probable, and definite OAG increases significantly as age increases (Fifty percent of the definite OAG participants were undiagnosed).

Mukesh BN. Ophthalmology June 2002; 109: 1047-1051

SENSITIVITY / SPECIFICITY OF SITA

Ninety normal subjects and 82 glaucoma patients had central 30° fields were performed with the Humphrey visual field analyzer 30-2 program using full threshold, SITA standard, and SITA fast on the same day for two or more sessions within a 1-month period. The sensitivity of SITA standard and SITA fast in detecting glaucomatous defects overall was 98% and 95%. In the subset of mild glaucomatous field defects, sensitivity of SITA standard was 92% versus 85% with SITA fast. Sensitivity was 100% for both algorithms in moderate to severe glaucomatous defects. Specificity for glaucoma defects using SITA standard and SITA fast was 96% for both algorithms. SITA standard reduced test-taking time from full threshold by 52% in normal subjects and 47% in glaucoma. SITA fast reduced test-taking time by 72% in normal subjects and 65% in glaucoma patients. Mean deviation values were 0.4 dB and 0.8 dB better in SITA standard and SITA fast fields, respectively, in normal subjects, and 0.7 dB and 1.2 dB in SITA standard and SITA fast fields, respectively, in glaucoma patients compared with full threshold values.

Budenz DL, et al. Ophthalmology June 2002 109: 1052-1058

FIVE YEAR INCIDENCE OF ARM

2335 (75%) survivors of the original 3654 participants of the Blue Mountains Study over aged 49 years or older attended 5-year follow-up examinations. Incidence rates for all ARM lesions increased significantly with age. For late ARM lesions (geographic atrophy and neovascular ARM), the overall 5-year incidence was 1.1%. The overall 5-year incidence of early ARM was 8.7%. The incidence of neovascular ARM in women was double that for men. The slightly higher incidence of hyperpigmentation found in our population compared with the Beaver Dam Eye Study may be due to sample variability, or this could reflect real differences between the two populations. Our lower incidence of soft drusen could have resulted from our noninclusion of intermediate soft drusen in the soft distinct and indistinct drusen categories.

Mitchell P, et al. Ophthalmology June 2002; 109: 1092-1097

IV FOMIVIRSEN FOR CMV

A multicenter, prospective, and randomized clinical trial compared immediate treatment of CMV retinitis with fomivirsen (165 g administered intravitreally) to deferral of treatment until CMV retinitis lesions progressed by standard definitions. Patients in the immediate treatment group (n = 18) and the deferral of treatment group (n = 10) were comparable at baseline. Median time to first progression of disease for the immediate treatment group was 71 days and for the deferral of treatment group was 13 days. Progression occurred in 44% of patients in the immediate treatment group during the study compared with 70% of patients in the deferral of treatment group during the study. There were no retinal detachments among eyes treated with fomivirsen.

The Vitravene Study Group. AJO; April 2002: 133: 467-474.

BIRDSHOT RETINOCHORODITIS

Of the 14 patients with birdshot retinochoroiditis who were tested, all were HLA-A29-positive. Retinal function in birdshot retinochoroiditis deteriorated progressively over a period of years despite stable visual acuity. Late in the course of disease, visual acuity may be lost due to chorioretinal atrophy in the posterior pole. Visual acuity alone is not an adequate parameter with which to monitor disease activity and may falsely suggest that a patient is stable or doing well. Intermittent treatment of the

inflammatory exacerbations did not prevent progressive visual loss. Other treatment strategies such as prolonged corticosteroid or immunosuppressive treatment should be investigated for patients with birdshot retinochoroiditis.

Oh KT, et al. AJO May 2002; 133: 622-629.

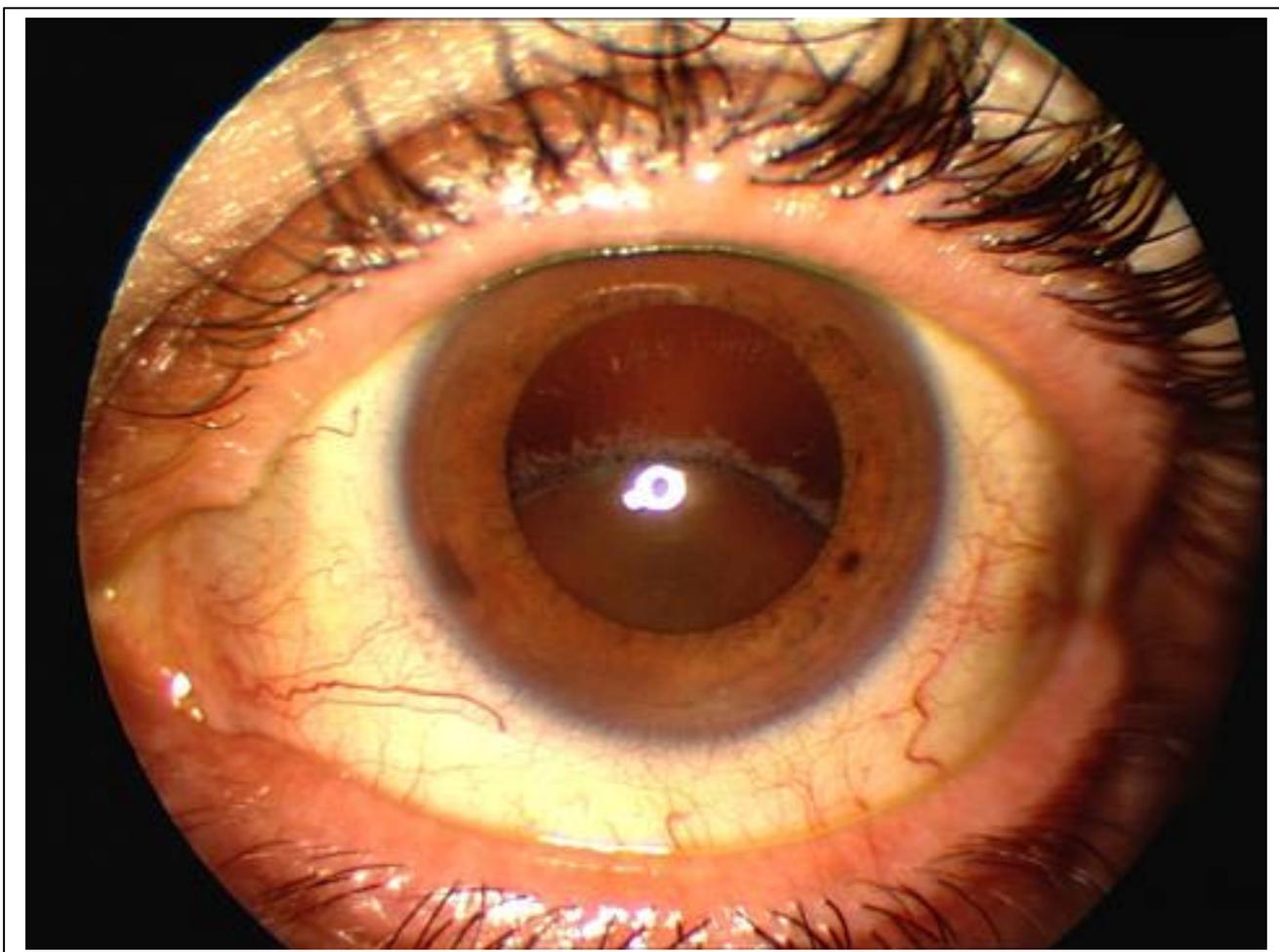
BLINDNESS AND GLAUCOMA

Patients at greatest risk of blindness had visual field loss at the time of diagnosis of glaucoma. Different susceptibilities to IOP were apparent, with some patients becoming blind at pressures that others tolerated without significant progression. This suggests that continued monitoring of visual fields and reassessment of target IOP levels when field damage occurs are fundamental in the management of glaucoma.

Oliver JE, et al. AJO June 2002; 133: 764-772.

Interesting Photo

Submitted by John M. Spalding, OD
VA Healthcare Center, Orlando, FL



Thoroughbreds

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

Lectured:

Rex Ballinger, [AOA Congress](#), 06/02, Preventing Vision Loss From AMD

Steven Ferrucci, [AOA Congress](#), 06/02, Advances in Diabetic Retinopathy Management

Murray Fingeret, [AOA Congress](#), 06/02, Controversies in Glaucoma Therapy, The Role of Genetics in Glaucoma and Advances in the Diagnosis of Glaucoma

Published:

Hoobyar AR, Ferrucci S, Anderson SF. and Townsend JC. Juxtapapillary Capillary Hemangioblastoma. [Optometry and Vision Science](#). June 2002; 79 (6): 346-352.

Lyons-Wait VA, Anderson SF. and Townsend JC. (co-authors with others). Ocular and Systemic Findings and Their Correlation with Hemodynamically Significant Carotid Artery Stenosis: A Retrospective Study. [Optometry and Vision Science](#). June 2002; 79 (6): 353-362.

Norden LC et al. Quality Assessment and Improvement in Optometric Practices . [Optometry](#). May 2002; 73 (5): 267-294

Calendar

Important dates to remember.

September 11-14, 2002

Vision Expo West, Las Vegas, NV, <http://www.vision.reedexpo.com>

October 20-23, 2002

Academy of Ophthalmology, Orlando, FL, <http://www.aao.org/aaoweb1/Meetings/11360.cfm>

October 26-27, 2002

VISN 8 CE Meeting, Ft. Lauderdale, Florida. 8 Hours of COPE and TQ. All VA O.D.s are invited. The educational fee is waived for the first 50 registrants before July 1, 2002.

Contact: joseph.molinari@med.va.gov

December 12-16 2002

AAO Annual Meeting, San Diego, CA, <http://www.aaopt.org/meetings/meeting3/index.asp>

Internet Links

Suggested web sites.

JOURNALS

Archives of Ophthalmology, <http://archopht.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.slackinc.com/eye/pcon/pconhome.asp>

Review of Optometry, <http://www.revoptom.com/>

Review of Ophthalmology, <http://www.revophth.com/>

MISCELLANEOUS

Medscape Ophthalmology, <http://www.medscape.com/ophthalmologyhome> (UPDATED)

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.aonet.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://www.va.gov/optsvc/index.htm>

EDUCATIONAL

Bascom Palmer Eye Institute, <http://129.171.73.73/prod06.htm>

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/>

Open Positions

Positions available within the VA.

Altoona, PA 1Position FT, James Andros 814-943-8164x7039

Asheville, NC 2 Positions PT, Calvin Jager 828-298-7911x5438

Beckley, WV 1Position FT, JC Crouch 304-255-2121x4460

Cillichothé, OH 1Position FT, Nate Darden 740-773-1141x7069

Columbia, MO 1 Position FT, Debbie Hettler 573-814-6575

East Orange, NJ 1 Position FT, Dr. Janis White 9736761000x2717

El-Paso, TX 1 Position FT, Susan Parks: slparks@hotmail.com

Hampton, VA 1 Position FT, Dr. Gay Tokumaru, 757-722-9961x3574

Loma Linda, CA 1 Position FT, Sharon Takayesu, 9089-825-7084x2438

Los Angeles, CA 1 Position FT, David Bright 310-268-3332

Montgomery, AL 1 Position FT, Johnny Bannister 334-272-4670x4337

Mt. Vernon, MO 1 Position FT, Dr. Mary J. Horn 501-443-4301x5661

Oklahoma City, Oklahoma 2 Positions FT, Jeff Disalvatore 405-270-5161

Orlando, FL 1 Position FT, Jodi Molley-Strudwick 407-629-1599x1522

Salisbury, NC 2 Positions FT, Dr. Gary Mancil 704-638-9000x3295

Shreveport, LA 1 Position FT, Terence Whatley 318-841-4744

Washington, DC 1 Position PT, Sam Belkiin 202-745-8347

White River Junction, VT 1 Position PT, Dr. Dorothy Hitchmoth 802-295-9363x5248

For More Information, contact Valerie Jarrard at: valerie.jarrard@med.va.gov

Miscellaneous Information

- **VA Recruitment / Retention Survey Highlights**

85 Responses out of 205 Surveys Sent = 41.5% Response Rate
Average Total Years in Practice = 15.3 (range 2-35)
Average Total Years in VA Practice = 10.9 (range 1-25)
Average Grade = 13.8
Average VA Salary 1999 = \$82748 2002 = \$93991
Completed a VA Residency = 64%

For More Information:

See 6-21-02 Optometry Conference Call Attachments on MS-Outlook

- **Blind Rehabilitation Centers**

by Jim Burns, MA, at Hines VA Hospital

The Central Blind Rehabilitation Center (CBRC), at Hines VA Hospital, became the second blind rehabilitation facility in the nation to receive accreditation from the commission for the accreditation of rehabilitation facilities (CARF) last fall. CARF praised all aspects of the program and after issuing the three-year accreditation had no suggestions for improvement. The individuals critiquing the CBRC recognized it as a world leader and recommended that information about their program be shared with other eye care professionals and related fields.

Blind rehabilitation centers have relied upon the services of Optometrists since 1973. This relationship continues to be key to

the success of these facilities. Doctors who diagnose any veteran as legally blind refer them to services through a visual impairment services team (VIST) coordinator. At that point Optometrists within the centers work side by side with blind rehabilitation specialists to provide a comprehensive team approach to rehabilitating the visually impaired veteran. Since the role of the Optometrist is so vital the staff at Hines elected to approach VA Optometrists before others.

Currently there are 10 blind rehabilitation centers strategically located across the United States. After being assessed, training is provided for patients in the areas of visual skills, orientation and mobility, activities of daily living, communications, Braille and manual skills. Each skill area is designed to assist the veteran in reaching the highest level of independence possible in all aspects of daily life. Length of stay at these residential facilities is dependent upon the individual needs of the veteran. Currently the average program lasts six weeks.

Between the veteran's increase in overall independence, and the effect it has on their self-esteem and family relationships, the success of VA blind rehabilitation facilities is undeniable. In a recent follow-up survey 98 percent of the veterans questioned said they would strongly recommend our services to others.

- **NAVAO Board Members**

President: Gerald Selvin, O.D., gerald.selvin@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

Newsletter Editor: John Spalding, O.D., john.spalding@med.va.gov

Membership: Rebecca Sterner, O.D., rebecca.sterner@med.va.gov

- **VA Optometry Mentor Program**

If you are interested in being a mentor to a newly hired VA optometrist, please contact Dr. Rebecca Sterner: rebecca.sterner@med.va.gov. Each newly hired VA optometrist will be given a list of mentors and VISN Consultants to contact should the need arise.

- **Newsletter Publication Dates**

January 15th
April 15th
July 15th
October 15th

- **Content Submissions / Suggestions**

John M. Spalding, OD, FAAO
VA Healthcare Center - Eye Clinic
5201 Raymond Street
Orlando, FL 32803
Ph: 407-629-1599x1725
Fax: 407-599-1340
E-mail: john.spalding@med.va.gov