

Omni Eye Services is proud to be a major contributor and supporter of the Oral Pharmaceutical Certification Course

The Observer

SUMMER 2007

EXTEND THE POWER OF YOUR PRACTICE

both all the best in their future endeavors.

Thinking Snow?

Back by popular demand, Omni's annual Killington Ski Conference is scheduled for February 8th -10th, 2008 at the Killington Grand Hotel in Killington, Vermont. Mark your calendars—not only do you get quality courses, but also quality skiing. Its fun for the entire family! Registration material will be going out in the fall. Hope to see you there!



Take full advantage of all we have to offer!

2007 CONTINUING EDUCATION SCHEDULE

We would like to invite you to earn your credits through the many continuing education courses offered by Omni Eye Services. Supporting optometrists will take precedence given limited seating. If you are interested in attending any of our Continuing Education courses, please contact Elaine Schultz at (732) 750-0400 x148, or elaines@omnieyeservices.com to register. Please check our website for updates on this year's schedule - www.omnieyeservices.com.

September 18th Tuesday Rochelle Park Office 6:00-8:00 pm	Gonioscopy Workshop Mike Veliky, O.D. 2 TPA	October 18th Thursday Parsippany Office 6:00-8:00 pm	Retina Grand Rounds Burton Wisotsky, M.D. 2 TPA
September 25th Tuesday Parsippany Office 6:00-8:00 pm	Oral Pharmaceutical Application John Insigna, O.D. 2 TPA	November 14th Wednesday Rochelle Park Office 6:00-8:00 pm	Retina Grand Rounds Burton Wisotsky, M.D. 2 TPA
October 11th Thursday Rochelle Park Office 6:00-8:00 pm	Strabismus Joseph Napolitano, M.D. 2 TPA	December 13th Thursday Iselin Office 6:00-8:00 pm	Gonioscopy Workshop George Veliky, O.D. 2 TPA



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Got Acanthamoeba??

At this point, we have all received calls from our contact lens patients concerned about Acanthamoeba keratitis. Although rare, these infections do seem to be on the rise. As a primary eye care provider, it is our responsibility to educate ourselves in order to identify these infections. Generally, our contact lens patients are at the highest risk for these infections. Acanthamoeba are parasites capable of infecting the cornea. These organisms can be found in soil, fresh water, tap water, swimming pools, lakes, hot tubs, contact lenses, lens cases and solutions. Acanthamoeba are resistant to temperature extremes because they have the ability to encyst. Patients presenting with Acanthamoeba keratitis often experience severe pain. Corneal infiltrates may be present which commonly coalesce into a partial or complete ring. The overlying epithelium may be intact, ulcerate or develop recurrent erosions. Keratoneuritis can also be seen in these infections. These are unusual infiltrates which occur along the course of corneal nerves. Multiple nerves may be involved and often are located in the mid stroma just outside the visual axis. These infiltrates can progress rapidly in a branching pattern and reach the limbus. Ring infiltrates and keratoneuritis are hallmarks of Acanthamoeba keratitis. Treatment of these infections can be challenging and patients often require surgical intervention. If you suspect one of these infections, consider a corneal consultation. These patients are often misdiagnosed and the visual prognosis can be grave. The best treatment is prevention. These infections can be greatly reduced by re-educating your patients regarding their contact lens disinfection and storage, and by stressing the importance of regular follow up care in your office.

Word on the Street

“Can you review how to evaluate a patient who has had bleb surgery? Also, what are the current thoughts with regards to valve surgery?”

The management of a patient who has undergone glaucoma filtering surgery requires careful post-operative care. Without appropriate intervention at the correct time, surgical failure and perhaps vision threatening complications may



occur. The appearance of a functional filtering bleb varies depending on the surgical approach utilized. Fornix-based blebs may appear lower and more diffuse, while limbus-based blebs will be more localized and elevated. Dr. Grayson typically performs fornix-based blebs. Best function is achieved when the filtration site is ischemic. Conjunctival injection surrounding the surgical site can lead to bleb failure and may be an indicator of blebitis or early endophthalmitis, especially if present in the later postoperative period. The bleb should have a moist, lobular appearance and the walls of the bleb may contain microcysts, an indicator of aqueous filtration. An ischemic diffuse bleb with an IOP in the single digits or low teens usually indicates a well-functioning filter. However, a low IOP is not the sole criterion of bleb function. A flat bleb accompanied by low IOP may indicate a choroidal effusion or a bleb leak. These scenarios need to be recognized and treated promptly.

Complications associated with a trabeculectomy are related to the nature of the procedure. An open communication from the interior of the eye to the sub-conjunctival space has been created and the aqueous dynamics of the eye have been altered. Over-filtration may result in hypotony, hypotonous maculopathy, choroidal effusion, choroidal hemorrhage, or a flat anterior chamber. Surgical failure with uncontrolled IOP is possible at any point during the postoperative period. Bleb leaks may also occur at any time and provide access for microorganisms to the interior of the eye increasing the risk for infectious endophthalmitis. Aqueous misdirection is another potential complication seen in trabeculectomy surgery. Posterior ciliary body rotation results in aqueous being directed into the vitreous cavity. A patient in misdirection will often have a shallowed anterior chamber with elevated IOP.

Glaucoma drainage implants are another viable option for glaucoma patients requiring advanced intervention. Aqueous is shunted from the anterior chamber to a distal reservoir from which it will be absorbed into the conjunctival lymphatic and venous circulation, as well as into the tear film. The two most common glaucoma implants are the Ahmed valve and the Baerveldt implant. The Ahmed device contains a one-way valve designed to prevent flow into the reservoir in case the pressure within the eye is too low postoperatively. The Ahmed has a higher potential for mechanical failure, an increased tendency for tenons cyst formation, and a greater risk of

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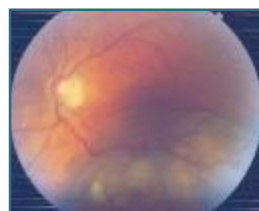
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postoperative strabismus. The Baerveldt drainage implant has no mechanical valve system and has a lower more diffuse profile with an increased surface area. The device is implanted with a surgeon-installed releasable ligature system. The ligature temporarily slows aqueous access to the reservoir in order to avoid unrestricted outflow and hypotony in the early postoperative period. Ligature techniques vary and include self-dissolving sutures, non-dissolvable sutures which can be released utilizing an argon laser, or a "rip cord" approach in which the lumen of the seton is partially occluded with a nylon suture that is left accessible for future removal.

Patients at high risk for trabeculectomy failure, including neovascular, uveitic, and iridocorneal endothelial syndrome glaucomas, are excellent implant candidates. Patients who have fibrotic, non-viable conjunctiva due to previous surgical intervention may also be better managed with a glaucoma implant. Potential complications of glaucoma implants include hypotony, device failure, serous or hemorrhagic choroidal detachments, or infection. Additionally, erosion of the tube through the patch graft and overlying conjunctiva, as well as tube migration, may be observed. Corneal decompensation occasionally can occur with seton implantation.

The incidence of complications following trabeculectomy or glaucoma implant placement is variable, however, they can be greatly reduced through appropriate, timely detection and communication with your patient's surgeon. Glaucoma surgery is a highly successful and safe option when performed by an experienced surgeon who is also prepared and available to manage unforeseen postoperative events with you.

Retinal Observation



A 68 year old Caucasian male presented with the complaint of decreasing vision in his left eye for the past four months. His best corrected vision measured 20/20 in the right eye and finger counting at four feet in the left. A dark greenish brown lesion was visible in the inferior portion of the retina. A serous retinal detachment was present over this lesion with no associated

retinal breaks. This lesion represented a choroidal melanoma with an associated exudative retinal detachment. It has been found that the larger and more anterior an uveal tumor is located, the greater the risk of death from metastatic disease. According to the Collaborative Ocular Melanoma Study, treatment of these lesions is based on the height of the lesion. Melanomas are classified as small (<3mm), medium (5-10mm), or large (>15mm). Treatment strategies depend on size and can include observation, some form of radiation or enucleation. This melanoma was characterized as large due to the fact that it measured greater than 15mm in height. Through a multi-disciplinary approach, the decision was made to enucleate the eye in an attempt to extend the patient's life.

Pharmaceutical Forum

Ocular Toxoplasmosis

Retinochoroiditis due to the intracellular protozoan parasite *Toxoplasma gondii* can arise from a congenital or acquired infection. Congenital infections occur due to maternal exposure during pregnancy. The most common cause of infection is through exposure to contaminated cat feces. Toxoplasmic protozoa enter the eye through the systemic circulation and have a predilection for the retinal nerve fiber layer. The organism may then actively invade cells allowing for a necrotizing retinochoroiditis. Infection with toxoplasmosis is one of the leading causes of posterior uveitis in this country. Assuming an immune competent patient, organisms will become encysted and the infection will be neutralized. These encysted organisms may remain viable for over 25 years and have the ability to reactivate. Intervention is indicated when the active infection threatens the macula, the optic nerve, or if the lesion is severe enough to cause vitreous traction or retinal detachment.

Historically, ocular toxoplasmosis has been treated with a combination of Pyrimethamine 75mg loading dose followed by 25mg BID, Sulfadiazine 2g loading dose followed by 1g QID, and Folinic acid 3-5mg twice weekly to minimize bone marrow suppression. Side effects of these medications include Stevens-Johnson syndrome, kidney stones, bone marrow depression, and membranous colitis. Newer alternatives have lower side effect profiles and an easier dosing schedule. One such option is Bactrim DS. Bactrim DS is a combination drug containing

sulphamethoxazole and trimethoprim. It is dosed twice a day and is usually well tolerated. It is recommended that therapy for toxoplasmosis continue for six weeks. Oral corticosteroids can be introduced after antibiotics have been started to control inflammation. Dosing will be dependent on the severity of the inflammation, and can range from 20-100mg a day.

Ocular toxoplasmosis is relatively common and can be devastating to vision. The goal with these patients is to diagnose them accurately and begin treatment to control the active infection if the infection is located in a visually threatening location limiting potential damage. Recurrences are a possibility, therefore patients need to seek care immediately should their symptoms return.

Manan Shah, MD: Providing Specialized Corneal Care

Since Dr. Manan Shah has joined our practice, he has been received very well by our referring network and their patients. The current clinical environment is very different from years ago. With the increased incidence of Fusarium and Acanthamoeba infections, there is a real need for your practice to have a corneal specialist available to provide secondary and tertiary care. As a referring doctor, be confident your patients will receive the most advanced care through our corneal service. Dr. Shah is looking forward to assisting you in the care of your corneal and cataract patients.

Napolitano Volunteers During Special Olympics

New Jersey's annual Special Olympics were held on the weekend of June 2nd at The College of New Jersey in Ewing. Over 2,500 athletes and thousands of volunteers made this year's event a huge success. Traditionally, a vision screening is conducted at the event and this year was no



Dr. Napolitano's daughter, Nina (on right), also volunteered at the event.

exception. Through the Opening Eyes program, vision screenings, examinations, and protective eyewear were provided to the athletes. Omni's own Joseph Napolitano, M.D. provided his time and expertise and worked along side optometrists from across New Jersey to care for approximately 300 athletes. Over 130 pairs of glasses were prescribed as a result of their efforts.

Insinga and Grayson Discuss Glaucoma Co-Management

Drs. Insinga and Grayson were approached by the editors of Review of Optometry to provide input for the upcoming issue's co-management Q&A section. The piece provides useful information concerning the postoperative evaluation of patients who have undergone glaucoma filtering surgery. Additionally, they discuss the latest concepts in the field of drainage implant devices in a question and answer format. Be on the look out for this informative discussion - it is sure to provide you with valuable information to assist you in the care of your patients.

Omni Sends Representatives to AOA

Drs. Christopher Quinn and William Marcolini lectured at this year's American Optometric Association's meeting. The meeting took place in Boston from June 27th to July 1st. Their topic centered on the newest technology in anterior segment imaging and its application in the detection of ocular diseases. The course was entitled "Anterior Segment Imaging: Frontline for Detection of Fungus, Parasites and Glaucoma."

Farewell to 2006/2007 Residents

With the onset of summer, Omni sets forth another pair of highly trained optometric physicians. Drs. Neeta G. Kapoor and Markitta S. Jemerson-Dixon have spent the past year working along side our specialists gaining insight into the management of complex eye diseases. Additionally, thanks to all of our referring doctors—they have experienced first hand the workings of an optometric referral center. Currently, residency training within optometry is purely voluntary. Both of these fine doctors should be commended for their commitment and achievement. Drs. Kapoor and Dixon have taken it upon themselves to expand their knowledge in order to better serve their future patients. All of us here at Omni wish them

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