

PSS NEWS

To my colleagues,

Welcome to the June edition of PSS NEWS. Here are my thoughts for the month:

1. I recently moved to upstate New York after private practice in Connecticut for 20 years. One of the main privileges I lost when I moved to NY was orals. In fact, the state of New York is the last state still fighting this battle. I am pleased to see that we finally have some optimism in this battle. We have cleared one major hurdle; just one more to go and we will have oral therapeutics in NY as well.
2. As life returns to "normal" after the COVID pandemic, many of us will focus on our practices and try to recoup some of the income lost last year. Although some of it can be made up by seeing more patients, much of it will have to be done by practicing smarter, not just harder. The easiest way to do this is to practice to the full scope of what our state allows and to take advantage of our "high" ticket items such as dry eyes, keratoconus, glaucoma, and amniotic membranes.
3. By the end of 2021, I hope that most or all optometric meetings will return to the true LIVE format. Although you can get the same education by a webinar, the interaction and comradery with colleagues is what's lost. We all are so busy in our personal lives, optometric meetings are one of the few venues in which we can socialize with other optometrists. Now, more than ever, we have to stick together to keep our profession moving forward.

REMEMBER: You can email me your comments, editorials or a 2-3 sentence job posting for FREE! If you wish to post something, please email me at deegup4919@hotmail.com or Sonia at education@psseyecare.com

Deepak

Deepak Gupta, OD

PSS EYECARE 2021 MEETINGS

June 12 -13 Niagara Falls NY
 September 11-12 Mystic CT
 September 25-26 Tysons Corner VA
 October 23-24 Orlando FL
 November 13-14 Atlanta GA
 LIVE WEBINAR – September 2021

PSS EYECARE 2021 SPEAKERS

Pinakin Davey

Tim Earley

Steven Ferrucci

Susan Gromacki

Ron Melton

Jerome Sherman

Jeffrey Sonsino

Randall Thomas



Deepak Gupta
 Course Director, PSS EyeCare

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 website

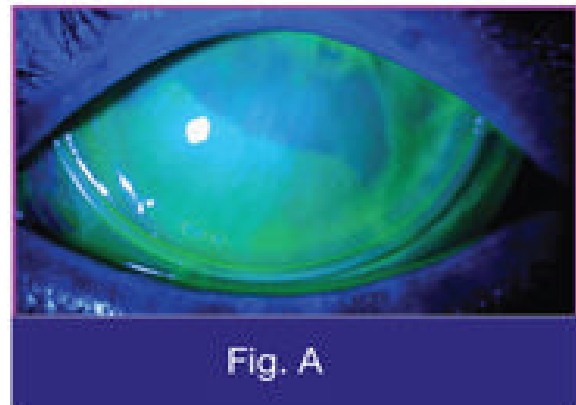
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Lessons

Many ODs are embracing the medical model of optometry which includes the diagnosis and treatment of anterior segment disease. One particular area of interest is the use of amniotic membranes in treating disease. The versatility of this technology and the option to utilize a modality beyond pharmaceuticals to facilitate tissue repair and regeneration can improve overall outcomes.

What is an Amniotic Membrane?

The amniotic sac that surrounds a baby during gestation has been known to exhibit amazing anti-inflammatory, anti-scarring, and antimicrobial characteristics. The use of this amniotic tissue in disease management arises from harvesting it from the mother's placenta after normal delivery of the baby. Of particular interest to eyecare providers is that this tissue is primarily composed of collagen types IV and VII (fibronectin and laminin), two common components of the ocular surface and cornea. This amniotic membrane also contains hyaluronic acid which can inhibit pro-inflammatory cells and suppress T-cell activation.



The Science

Amniotic membrane grafts were first researched for ocular conditions more than 60 years ago, but stable application to the eye was not successful until 1995. We have come a long way since then. Amniotic membranes have been shown to promote epithelialization, decrease inflammation and scarring, prevent or reduce neovascularization, and improve overall patient comfort.

A lot of the regenerative properties of amniotic tissue have been linked to a molecular complex called HC-HA/PTX3. The highest concentration of this complex is found in fresh amniotic tissue, but this is almost never used in clinical practice. Cryopreserved amniotic membranes have the next highest concentration while dehydrated amniotic membranes have the lowest amounts of HC-HA/PTX3.

The Benefit

Amniotic membranes have been shown to offer significant anti-inflammatory, anti-scarring, anti-neovascular, pain relief and regenerative healing properties. They can do so without the risk of IOP spikes or delayed healing which can be found with topical steroids.

In many cases, these patients would have previously been ones we had to send to an ophthalmologist. With the emergence of this technology, we can now handle many of these patients ourselves!

KEEP IN MIND...

If a patient needs adjunctive pharmaceutical therapy such as topical antibiotics and/or topical steroids, these can typically be applied on top of the amniotic membrane.

There are basically two kinds of amniotic membranes – dehydrated and cryopreserved. The most common and popular type of amniotic membrane used by optometrists is the cryopreserved. This graft is called Prokera by Biotissue. It is also the one I have the most clinical experience with so that is the technology I will focus on.

Dehydrated Amniotic Membranes

This type of amniotic membrane typically consists of a flat disc of tissue without a stabilizing outer ring. Application to the patient typically requires a little practice and the use of a lid speculum. After the graft is applied, it is smoothed out and centered over the involved area. At this point, a bandage contact lens is usually placed on the top of the membrane. When the lid speculum is removed, special attention must be paid to make sure not to damage the membrane or bandage contact lens. Two common examples of this kind of amniotic membrane are the AmbioDisk (IOP Ophthalmics) and BioDOpix (BioD).

COMMON INDICATIONS FOR USING AMNIOTIC MEMBRANES

Recurrent corneal erosion

Severe dry eyes

Neurotrophic ulcer

Persistent corneal epithelial defect

Chemical and thermal burn

Post-DSEK for bullous keratopathy

Salzmanns' nodular degeneration

Microbial ulcers

Herpes simplex keratitis

Herpes zoster keratitis



PROKERA

The Prokera amniotic membrane is secured within an ophthalmic conformer ring. All cell activity of the tissue is inactivated to eliminate the possibility for graft rejection. It is stored in a medium that containing ciprofloxacin and amphotericin B. For optimal results, it should be stored frozen.

The Prokera family comes in several variations: Prokera, Prokera Slim, Prokera Clear, and Prokera

Plus. The different types allow the optometrist to customize the application based on the condition being treated. Prokera is indicated for conditions which results in damage to the ocular surface cells, underlying stroma, or any condition which can lead to permanent damage to ocular tissues and potentially impact vision. I find that the Prokera Slim is generally indicated for recurrent corneal erosion, severe dry eyes, non healing ulcers, neurotrophic epithelial defects, and/or severe corneal abrasions. Prokera should be used in patients where increased orbital space is preferred, such as patients with a droopy eyelid. Prokera Plus is for more severe conditions such as chemical burns and ocular trauma. Prokera Clear features a 6mm aperture to provide the patient with some vision while undergoing treatment. In my practice, I use the Prokera Slim almost exclusively and have had phenomenal success.

PROKERA INSERTION

The Prokera tissue arrives from the manufacturer frozen and must be stored either refrigerated or frozen. In either case, Prokera has a shelf-life of 2 years.

When it is time to use the membrane, you should remove the Prokera from the fridge or freezer and let it sit at room temperature in the unopened package for roughly 15 minutes. Be sure to thoroughly rinse prior to insertion because Prokera contains glycerol which will potentially sting if not fully rinsed.



1. Apply topical anesthesia



2. Hold the upper eyelid



3. Ask the patient to look down



4. Insert the PROKERA® into the superior fornix



5. Pull lower eyelid down and slide the PROKERA® under the lower eyelid



6. Check centration under the Slit Lamp

* Apply appropriate medications (As Needed)

Most patients will tolerate the membrane without needing to do anything else. If the patient is uncomfortable, you can apply a tape tarsorrhaphy over the superior lid. I rarely end up having to do this. If I do, it is with the Prokera or Prokera Plus, never with the Prokera slim.



1. Apply topical anesthesia



2. Pull the lower eyelid down



3. Lift the lower edge of PROKERA® using a Q-Tip or forceps



4. Ask the patient to look down



5. Apply gentle pressure on the upper eyelid



6. Slide the PROKERA® out

PROKERA REMOVAL

FDA regulations stipulate that a sutureless amniotic membrane cannot remain in the eye for more than 29 days. That is not a concern in my practice. Although there is some variability depending on the clinical condition, I typically see the patient back in 3-5 days following membrane insertion at which point I remove it.

BILLING

The use of these membranes is billed under CPT code 65778 "Placement of amniotic membrane on the ocular surface; without sutures." This code does not have a global period so you can bill for an office visit when the patient returns for removal.

In terms of insurance coverage, a separate charge and reimbursement for the supply of the amniotic membrane is not allowed; it is bundled into the reimbursement for the procedure itself. Please also note that the use of amniotic membrane is considered a minor surgical procedure so an office visit (either 920XX or 992XX) is generally not allowed when performed on the same date of service as CPT code 65778.

Most state boards of optometry have deemed the placement of amniotic membranes to be within the optometric scope of practice however you should check with your state regulations before performing these procedures. You will find them very beneficial to have them in your arsenal.

Find Your

Wow Moment

When **Good Enough is Not Enough**



Choose **PROKERA**[®]



Contains the Only Cryopreserved
Amniotic Membrane FDA cleared & designated
for Anti-inflammation & Anti-scarring



Delivers Patient Satisfaction
due to Premium Outcomes



Easy to Handle and Insert



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Roanoke, VA

National Optical in Roanoke VA, looking for a full/part time Optometrist. Please contact Tom Cox at 540-362-0300 for more information.

EDITORIAL

"Now it seems more and more OD's are using the Optos as an excuse for not dilating and actually seeing the retinal changes. Is it laziness, not getting paid enough for complete exams or lack of ability to use the SL lenses and BIO?"

Laziness is not excusable. Not getting paid enough is our fault of allowing VCP's to control our fees. Incompetence is related to poor clinical skills from lack of clinical patients seen at all OD schools."

- From R.R., Delray Beach, Florida

REPLY FROM THE EDITOR

"I agree with all 3 statements. I think it's terrible that ODs don't realize the true benefits of dilation... and that Optos is not a substitute. To me there is nothing that underscores the fact that a patient is having an ocular health exam more than dilation."

-- Deepak

CASE STUDIES FROM THE TRENCHES

A 49 y.o. African American male presented for a routine eye exam because "his regular doctor" told him he should have one. He broke his eyeglasses 1 month ago and desperately needs a new pair. His Ocular and Family History is negative. He is Diabetic x 10 years and takes a combination of insulin and oral medications. His fasting blood glucose runs roughly 170 and his last A1C was 9.4.

His entering VA was 20/80 OD, 20/60 at distance and J1- at near OU. Manifest refraction revealed a prescription of -1.75 SPH OD 20/20 and -1.00 -.50 x 180 OS 20/20. All other entrance exams and slit lamp examination was normal.

Sadly he refused dilation even after being educated about the need to do so. Now what should we do with this patient?

How would you handle this? Is his diabetes under control?

Find out what I did in the next issue

LAST MONTH'S CASE STUDY

I recently had a mother and father who I have been seeing for almost 10 years come in for a comprehensive eye exam. The father has a prescription of -5.50 OU and the mother -7.00. Both have worn eyeglasses and/or contact lenses for almost 25 years. They started bringing their daughter in for an eye exam when she was 5 years old. The child has been 20/20 uncorrected at each visit. All other ocular health findings have been negative.

At her most recent exam, their daughter HH (now 11 years old) had VA of 20/40 OD and 20/30- OS. Manifest and cycloplegic refraction revealed a prescription of -.75 OD and OS getting to 20/20 vision. Both parents are extremely concerned and want to know what they can do to prevent her from having vision as bad as they have.

WHAT I DID FOR THIS PATIENT

1. First thing I do in these situations is to educate the patient. Although it may seem terrible to be dependent on eyeglasses and/or contact lenses, at least the eyes are healthy. So many other patients have amblyopia, glaucoma or macular degeneration so they don't know what good vision is.
2. We can try some things, but nothing will reverse the myopia which has occurred. In the vast majority of patients, all we can do is slow the myopia down.
3. New contact lenses which are aimed at myopia control.
4. Take eyeglasses off when doing prolonged near work. This unfortunately makes it less desirable for these patients to wear contact lenses.
5. Keep them slightly undercorrected by .50D.
6. Send them outside. Many studies have shown that kids that play 1 hour or more outside tend to progress less.

IF YOU HAVE OTHER SUGGESTIONS, FEEL FREE TO SEND THEM TO US

SEE YOU NEXT MONTH. BE SURE TO CHECK OUT THIS MONTH'S CASE STUDY

PSS EYECARE 2021 FALL MEETINGS

All meetings are LIVE and include breakfast and lunch

September 11 & 12 – Mystic CT
20 COPE/FL Board Hours

September 25 & 26 – Tysons Corner VA
20 COPE/FL Board Hours

October 23 & 24 – Orlando FL
18 COPE/FL Board Hours

November 13 & 14, 2021 – Atlanta GA
18 COPE/FL Board Hours

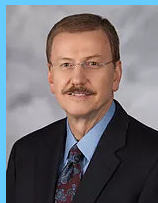
All new courses centered around helping optometrists to build a medical practice and generate additional revenue for the practice. Courses include clinical updates plus information on how to integrate new technologies into clinical practice.

Glaucoma Diagnosis & Management
Role of Nutrition in Ocular Disease
Building a Dry Eye Center of Excellence
Case Studies in Disease Management

Anterior Segment Disease
Keratoconus Diagnosis & Management
Contact Lens Update
Hi Tech Procedures to Help Patients



Jeffrey Sonsino



Ron Melton



Randall Thomas



Jerome Sherman



Pinakin Davey



Deepak Gupta



Timothy Earley



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All will be conducted in a safe, socially distant environment
All courses will be COPE approved and submitted to FL board for approval.

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