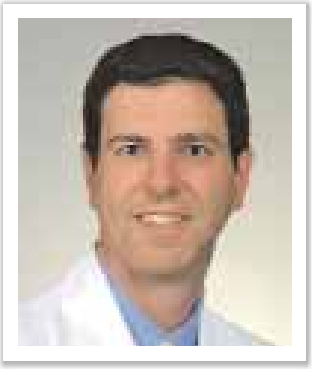
Kerry D. Solomon, MD

Dr. Solomon discusses the perks of academic medicine, the benefits of advanced phaco technology, and the joys of golf.

What do you enjoy most about academic medicine?

I enjoy interacting with residents and fellows. In addition to teaching them the basic skills they need to perform examinations and remove cataracts, I try to instill in them the principles and ethics that will expand their expertise beyond surgical techniques or technology. I want to stimulate their interest in research and give them a desire to share knowledge with others.



Every 4 to 6 weeks, the ophthalmology residents from the Medical University of South Carolina meet at my house for informal rounds. During these gatherings, we discuss political issues affecting the practice of ophthalmology and how doctors in training can contribute to the field by joining professional societies such as the AAO and the ASCRS. The residents and I also critique surgical videos—mine and theirs—which I believe stimulates them to improve their current skills and try new techniques. I have found that this less formal approach supplements the conventional didactic lectures that make up the rest of the university's curriculum, and it encourages residents to become involved in clinical research, seek creative opportunities, and stay on the cutting edge of ophthalmology.

How do you select patients for cataract and refractive surgery?

I think it is important to understand patients' motivations. What do they expect from premium IOLs, PRK, or LASIK? Some people will never be happy with the results of these procedures, and we need to recognize poor candidates before we schedule them for surgery. I find that discussing various options with my patients during their initial consultation helps me bond with them and increases the chances that they will be happy with their postoperative vision.

How has cataract surgery changed since you started practicing?

We now have the concept of refractive cataract surgery, which allows us to combine refractively neutral incisions with technologies that provide predictable visual outcomes. I implant multifocal IOLs that reduce patients' postoperative dependence on spectacles or contact lenses at all visual ranges, aspheric IOLs that improve contrast sensitivity, and toric IOLs that correct astigmatism. With these technologically advanced IOLs, I can do more than remove patients' cataracts. I can also rehabilitate their eyes and, in some cases, give them better vision than they had before their surgery.

What other advanced technologies have made the greatest difference in your practice?

I recently completely transitioned to torsional ultrasound. I have found that this technology is well suited to removing cataracts through smaller incisions, because its fluidics allow me to use lower flow settings while still maintaining maximal efficiency. Torsional ultrasound is so efficient that I rarely need to use conventional longitudinal ultrasound anymore.

I have also incorporated various drugs into my surgical routine, including intracameral vancomycin, topical fluoroquinolones, and NSAIDs. In my opinion, any patient with a cataract deserves an NSAID, especially if he is receiving premium IOLs. Patients implanted with multifocal IOLs are more likely to notice subtle changes in visual quality caused by postoperative cystoid macular edema than those who receive monofocal lenses. In my experience, treating patients with NSAIDs for 3 days preoperatively and 6 weeks postoperatively reduces their risk of developing cystoid macular edema, and it may improve their surgical outcomes.

What do you like to do when you are not working?

Besides spending time with my wife, Cindy, and our two young sons, I love to play golf. You might say that I am a golf nut. My younger son shares my interest in the sport, and I had the pleasure of serving as his caddy last summer when he played in a couple of tournaments. I enjoy watching him play as much as I enjoy playing myself. ■