OPTOMETRISTS AND INTEGRATED CARE OF OCULAR SURFACE DISEASE

This arrangement benefits all parties!

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Ocular surface disease (OSD) is ubiquitous in the ophthalmic literature. With diagnostics and treatment constantly evolving, it can be an overwhelming topic to fully understand. A seemingly simple problem often proves quite complex to treat effectively.

As new technologies emerge, practices across the country are branching out and reinventing themselves as dry eye disease (DED) treatment centers. These practices can be a vital resource for comanaging this challenging condition. Effective comanagement can begin with the staff optometrist in a medical office or with an optometrist from the practice's referral network.

A COMMON GOAL

Eye care providers—optometrists and ophthalmologists—are working toward a common goal: the best outcomes for their patients. Surgeons need a healthy ocular surface in order to provide the best possible vision to patients. Every ocular procedure from cataract surgery to blepharoplasty to glaucoma treatment to antivascular endothelial growth factor injections for age-related macular degeneration to especially corneal-based surgeries PRK and LASIK disrupts the ocular surface.

The most important factor when managing a patient with OSD is taking time with him or her. OSD is a complex condition, and patients range from being asymptomatic to having debilitating symptoms. These individuals often require hand-holding and education to understand the chronic and progressive nature of their condition. Ophthalmologists are focused on their surgical specialty; therefore, effectively treating OSD can be an unwelcome and time-consuming challenge.

Integrated care of these patients lessens this burden, frees up time for the ophthalmologist to see more surgical patients, and allows the optometrists to develop an effective treatment plan for both pre- and postsurgery to create a pristine ocular surface.

THE ROLE OF THE OPHTHALMOLOGIST

Research shows that a poor preoperative tear film can have a negative impact on the end result.[1,2] Data from a study by Trattler et al showed that many patients presenting for a cataract evaluation had OSD yet were asymptomatic.[1] In their study, 136 patients (272 eyes) presenting for routine cataract surgery were examined for signs and symptoms of DED before surgery. Only 22% of the patients had been told at some point in the past that they had DED, yet 77% had corneal keratitis.[1] Working as an optometrist (L.O.) in a busy surgical practice, I have observed that the disconnect can start even before the patient is referred for surgery.

Partnering with referring optometrists to develop a treatment plan prior to surgical referral can be a huge time saver. Having patients' OSD well controlled in advance of the surgical consultation will reduce the number of patients who, although asymptomatic preoperatively, suffer from ocular discomfort, vision fluctuations due to decreased tear breakup time, and increased inflammation in the postoperative period.

Proactively treating DED is especially critical for patients who opt for multifocal lens implants. Corneal drying results in refractive changes that are magnified by these IOLs, potentially causing distorted vision and unhappy patients.

Help the referring optometrist take control of this chronic disease. By investing in the referring network of optometrists through education and hands-on workshops, your surgical practice will grow.

THE ROLE OF THE OPTOMETRIST

For optometrists, treating OSD before the patient is referred for a surgical consultation is vital. They should be completing a thorough dry eye evaluation and educating patients on the condition. As mentioned, this is especially important for patients with nonobvious disease who are asymptomatic prior to surgery. High-volume surgical practices take great measures to evaluate the ocular surface prior to surgical procedures. Optometrists need to know it is not a good idea to refer patients to a surgeon if they do not have control of their OSD, as it slows down their care.

Optometrists choose surgeons who consistently have excellent outcomes for their patients. One of the biggest fears optometrists have when referring a patient is that his or her outcome will be less than favorable. For a cataract patient, endophthalmitis, although uncommon, is high on the list of concerns for postsurgical complications, yet new research shows that 59% of patients examined prior to cataract surgery had blepharitis and were once again asymptomatic.[2] Untreated, blepharitis can be a cause of postsurgical endophthalmitis.

Several other studies suggest that the prevalence of asymptomatic OSD in cataract patients is high and that cataract surgery can induce or exacerbate existing OSD.[3-5] Educating a patient begins with the referring optometrist. Patients with OSD must be well informed regarding the nature of the disease and how it can worsen in the postoperative period. Managing expectations and addressing concerns before referral and, more importantly, prior to surgery make for better outcomes. Managing expectations is something all cataract surgeons understand, especially for patients with multifocal IOLs.

DIAGNOSING OSD

Although diagnosing OSD can be a challenge, new advances in testing are making it easier. Start with a questionnaire. The Standard Patient Evaluation of Eye Dryness or SPEED questionnaire developed by Donald Korb, OD, is a fast way to assess a patient's symptoms before starting the examination. Like the Ocular Surface Disease Index or OSDI, the SPEED questionnaire is a validated survey.[6] Patients do not know what DED really means, but they do know that their eyes get tired with computer use or often feel gritty at the end of the day.

In eye care, we are armed with a battery of useful tests that aid in proper diagnosis. Tear osmolarity (TearLab) and InflammaDry (Rapid Pathogen Screening) are great tools that offer definitive information regarding patients' OSD and also increase practice revenue. These tests are variable, like IOP, and should be repeated at follow-up examinations to help guide treatment. The slit-lamp examination with vital dyes is a valuable tool as well and a great way to assess the meibomian glands with little added cost to your practice. Treatment can still prove to be a challenge. Many patients have combined disease with an aqueous deficiency and evaporative component. Allergies can further complicate the scenario. There is no one-size-fits-all approach for a DED patient.

TAKE-HOME MESSAGES

- Optometrists' managing OSD before referring patients for surgical consultation is critical.
- Eye care providers should perform a thorough DED evaluation and educate patients on the condition. This is especially important for patients with nonobvious disease who are asymptomatic prior to surgery.
- Know that surgical practices, especially those with a high volume of refractive surgery patients, take care to evaluate the ocular surface prior to surgical procedures.
- Optometrists who refer patients without good OSD control slow down patients' care and can potentially reduce its quality for the surgical patient.
- Embrace new technologies, keep up to date with research, and collaborate with other eye care professionals who are branching out and trying these new technologies for the greater good of your patients and their surgical outcomes. ■

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