The Interventional Glaucoma Congress is developing consensus statements that support safe, early glaucoma intervention.

The origin of the belief that glaucoma is a surgical disease is debatable. Should it be attributed to David Campbell, MD, who shared the perspective during a talk at an annual meeting of the American Glaucoma Society years ago? To S.D. Risley, AM, MD, PhD, who wrote about the surgical treatment of chronic glaucoma in 1907?[1] Why not credit Albrecht von Graefe, who performed the first surgical treatment for glaucoma—an iridectomy—in 1856? Regardless of the true source, these individuals and others paved the way for many evolutions in glaucoma management. Now, we are on the brink of a new era—the era of early intervention.

I remember talking to Iqbal Ike K. Ahmed, MD, FRCSC, and Richard Lewis, MD, years ago about the importance of intervening in the disease course early instead of waiting for an outcome like visual field loss. Granted, intervention is meaningless without the ability to predict accurately when patients will begin experiencing vision loss. In the past 20 years, however, surgical options to treat patients early in the disease course have emerged. Ab interno goniotomy with the Trabectome (NeoMedix, now MicroSurgical Technology) paved the way, not because the procedure was the first of its kind but rather because manufacturers found a way to get the device into the hands of more glaucoma specialists. Goniotomy then opened the door for trabecular meshwork–based procedures.

Ike and Rick have had a significant impact on the field of glaucoma. They both understand that intervening early in the course of glaucoma requires a proper diagnosis of the disease and safer procedures. They also understand what it takes to bring together glaucoma specialists with varying opinions and empower them to effect change. With these ideas in mind, Ike and Rick formed the Interventional Glaucoma Congress (IGC). The annual IGC meeting is a think tank where progressive glaucoma specialists exchange innovative ideas and promote a proactive rather than reactive approach to patient care. For the past 3 years, I have been their co-chair on the planning committee (Figure 1).

Figures courtesy of Laura Kinser

Figure 1. The 2022 IGC program chairs, from left to right, Dr. Lewis, Dr. Sheybani, Dr. Ahmed, and Rachel Simpson, MD.

ARSHAM SHEYBANI, MD

- Associate Professor, Ophthalmology and Visual Sciences, Washington University School of Medicine, St. Louis
- Associate Chief Medical Editor, *Glaucoma Today**
- sheybaniar@wustl.edu
- Financial disclosure: Consultant (AbbVie, Alcon, Santen, Nova Eye); Ad hoc consultant (Glaukos, New World Medical)

PUSHING BOUNDARIES IN GLAUCOMA CARE

**Glaucoma Today* is a sister publication to *CRST*

AN INTERVENTIONAL MINDSET

What's the vision behind the IGC? Understanding that requires revisiting the role von Graefe played when he treated the potentially devastating disease before the availability of any medical therapies. (Pilocarpine was not used until approximately 1875, and timolol was commercialized in 1978.) Medical glaucoma treatments have benefited patients, but side effects are problematic. The bigger issue, however, is that the availability of glaucoma drops made it easier for practitioners to ignore our inadequacy at treating the disease. We started to blame patients for noncompliance, but isn't that another way of saying that our therapies are inadequate?

The IGC is pushing the boundaries of glaucoma care by examining the role and timing of surgical intervention. The annual meeting challenges our thinking and inspires the next generation of glaucoma surgeons to find better ways to care for patients (for a fellow's perspective on the 2022 IGC meeting, see the accompanying sidebar). The members of the IGC are intimately involved in developing the content and format of the meeting, and each year, the conference has a different feel. From the inaugural congress in 2019, to a virtual meeting during the pandemic, to the incorporation of a fellows program in 2022 (Figure 2), the program continues to improve.

The IGC is currently developing consensus statements that support safe, early glaucoma intervention. The statements will tackle the following issues:

- Reimbursement challenges;
- Regulatory challenges;
- The unmet needs in clinical trials; and
- Surgical glaucoma training.

Glaucoma is a progressive disease. Without consensus on how to manage the incurable, noncompliant disease, we are wandering aimlessly. The mission of the IGC has always been and will continue to be to inspire an interventional mindset, where we treat the disease early before it has a functional impact on patients' vision and quality of life. ■

1. Risley SD. The surgical treatment of chronic glaucoma. *JAMA*. 1907;XLIX(4):291-299.

A CALL TO ARMS

BY ARIANA LEVIN, MD

I attended the fellows course and the main meeting at the Interventional Glaucoma Congress (IGC). At both, I was introduced to diverse approaches to glaucoma management. The meeting also challenged me to imagine glaucoma management 1, 5, and 10 years from now.

In a call to arms broadly applicable to all ophthalmology research, Matthew Schlenker, MD, urged IGC attendees to rethink statistics. The math used in study design dictates study outcomes. The math we choose therefore makes a difference to our patients. For example, reducing medication burden, lowering IOP, and slowing disease progression are all different outcomes. As a fellow, I have limited personal experience and short follow-up times on which to base my counseling. Consequently, I counsel my patients on the benefits of certain procedures according to published results.

Also at the IGC meeting, I attended an industry wet lab session and participated in a breakout case discussion led by Leon Herndon, MD, that focused on the Hydrus Microstent (Alcon). Practitioners shared their personal experiences, and we discussed how to manage challenges that can arise during device implantation as well as patient selection. I pursued a fellowship and residency in different geographic regions so that I would be exposed to a variety of patient populations. The differences in the epidemiology of glaucoma, patient access to health care, and systemic disease that I observed have improved my ability to tailor surgical decisions to my patients' needs. The roundtable discussion at IGC gave me an opportunity to learn how surgeons from institutions 800 miles away make surgical decisions for their patients. These perspectives are especially useful to me as a trainee who is about to transition from a fellowship to a first job.

ARIANA LEVIN, MD
Fellow, Washington University School of Medicine, St. Louis
levina@wustl.edu
Financial disclosure: None

Figure 2. Dr. Sheybani lectures during the fellows course at the 2022 IGC meeting.