

A COMMITMENT TO QUALITY OF LIFE



Safety and efficacy are no longer enough.

BY MANJOOL SHAH, MD

American psychologist Abraham Maslow in 1966 said, "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail." As glaucoma care providers, we have been living in a world ruled by Maslow's hammer. With limited medical and surgical options for our patients, we have often been forced to apply a one-size-fits-most solution to lowering IOP and, as a result, had to forgo individualizing care and taking quality of life into consideration. Our goal, first and foremost, is to prevent blindness, often by any means necessary. This has been and remains an admirable and challenging mission. However, with a variety of advances in glaucoma therapeutics, we finally have the ability to be nuanced in our delivery of care. From novel pharmacologic therapies such as nitric oxide donors and rho kinase inhibitors that may actually target the diseased outflow system, to the flourishing MIGS space, clinicians are now able to utilize finer, more delicate instruments to tailor care to the individual patient.

NEW FREEDOM, NEW RESPONSIBILITY

This freedom to tailor care certainly has its challenges, as with it comes a great number of responsibilities. It places an onus on all of us to become aware of the multiple treatment options available for our patients. It also demands that we be more observant of patient-specific challenges and unique subtypes of disease. We are finally able to ask the hard questions of ourselves and our patients with regard to quality of life.

No longer should we have to insist on a grin-and-bear-it approach to the side effects of glaucoma therapies.

INTEGRATING QUALITY OF LIFE

How can we better integrate quality of life concerns into glaucoma care? A low-hanging fruit is to look at the ocular surface. For a long time, we understood that medical therapies took a toll on the ocular surface, and we recognized that patients were suffering as a result. We were also aware of the impact that ocular surface disease could have on surgical outcomes. With interventional options that can spare this toxicity, conversations about preserving and protecting the ocular surface are now common. Although, in the past, we may have discontinued or modified medical therapy only due to either lack of efficacy or true allergy, we are now better able to respond to a greater range of patient-reported intolerances.

Further, in a broader sense we are starting to be more quantitative and scientific with regard to patient-reported outcomes in our field. Novel metrics are being designed to be integrated into medical and surgical trials. We are quantifying patients' fears and concerns about their disease and their therapy, and we may even be able to move toward using such metrics as an independent factor in the decision to engage in surgical intervention. The roles of patient education and motivational interviewing techniques are being evaluated and integrated into traditional care delivery models.

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BEYOND SAFETY AND EFFICACY

The glaucoma subspecialty has undergone tremendous change over the past decade with respect to therapeutic options, and we are at the cusp of another set of breakthroughs with regard to sustained-release pharmacotherapy. As we evaluate these tools and think about how to apply them to our therapeutic arsenals, the traditional duality of safety and efficacy are no longer enough. How patients feel about these therapies is equally important, and how they will affect patients' abilities to live happy and unburdened lives will and should be just as much a part of the conversation as the amount of IOP lowering a given treatment can achieve.

We are finally free to put down the hammer. ■

MANJOOL SHAH, MD

- Clinical Assistant Professor, Kellogg Eye Center, University of Michigan, Ann Arbor
- manjool@med.umich.edu
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