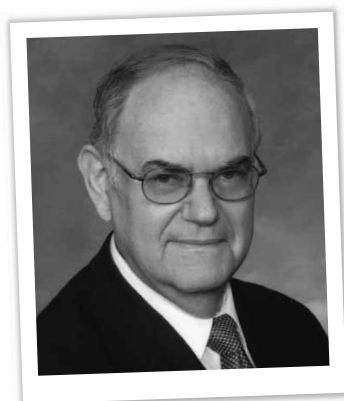


Allan E. Kolker, MD

Dr. Kolker reflects on ophthalmic training, his investigational work, and changes within the field of glaucoma.



1. What has shaped your ability to care for patients?

First was the recognition that every medical school and training program should teach physicians not only the facts of medicine but also how to learn. Because much of what we are taught during our training is soon outdated, our capability for continued learning is crucial to our ability to care for patients over time. I had the wonderful opportunity to learn from some of the greatest minds in ophthalmology, many of whom made remarkable contributions to our knowledge of glaucoma. Bernard Becker, MD, was Chairman of the Department of Ophthalmology at Washington University when I began my training. He was and is a unique individual who played a large role in the establishment of the National Eye Institute and developed one of the most superb programs in ophthalmology in the world. I also had the pleasure of knowing and often working with individuals such as Drs. Robert Shaffer, Joseph Haas, Franz Fankhauser, and even Hans Goldmann at the end of his career.

Second, I realized that glaucoma subspecialists are often the “internists” of ophthalmology. In reality, we treat patients who happen to have glaucoma. Doing so requires understanding the disease but also managing and understanding other ocular conditions that these individuals often develop. Patients with glaucoma are more likely to develop cataracts than the general population, and managing their cataracts can be quite different than routine cataract surgery, because these individuals frequently have miotic pupils and have undergone previous ocular surgery. In addition, glaucoma subspecialists often treat patients for their lifetimes. I still treat the first patient on whom I operated for infantile glaucoma 40 years ago, and I also see his daughters, who have the condition. The wonderful advantage of these long-term relationships is that glaucoma subspecialists can develop friendships with their patients.

2. How has the subspecialty of glaucoma changed since you began practicing medicine?

Because glaucoma is a chronic disease that increases in frequency with age, the number of patients with glaucoma is rising rapidly worldwide. Population estimates suggest that, by 2050, more than 1 million people older than 100 years of age will inhabit the US. For the first time in history, the number of individuals who are at least 60 years old will be greater than the number less than 15 years of age. Not long ago, the goal of glaucoma treatment was to slow its rate of progression until the patient reached 70 or 80 years of age. I now see as many as eight patients per day who are over 90 years of age and have suffered extensive glaucomatous visual loss, often because the solution of “losing vision slowly” proved inadequate. Several recent studies have demonstrated conclusively that sufficiently lowering IOP can prevent or markedly slow glaucomatous progression.

Individuals with glaucoma require far more attention, time, and intensive evaluation than most patients whom ophthalmologists see. Ours is a labor-intensive subspecialty. I am pleased by the dramatic improvements during my professional lifetime in our ability to treat and our understanding of the diseases comprising glaucoma. I am disturbed, however, that fewer and fewer residents are choosing glaucoma as their subspecialty, based at least partially on economic considerations. I have heard it said that, under the current health care system, one practices refractive surgery to make a living, cataract surgery to provide a service, and glaucoma as a hobby.

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FAST FACTS

- In private practice with Glaucoma Consultants of St. Louis
- Professor of Clinical Ophthalmology at Washington University School of Medicine in St. Louis and recipient of that institution's Alumni Faculty Award, 2002
- Member of the Board of Trustees for the AAO, 1994 to 1998; recipient of the AAO's Senior Honor Award, 1988; and recipient of the AAO's Lifetime Achievement Award, 2002
- Board Director for the American Board of Ophthalmology, 1994 to 1998
- Chairman of the Glaucoma 2001 National Scientific Advisory Board, 1996 to 1998
- Founding member of the American Glaucoma Society; President, 1992 to 1994; and recipient of the AGS Honor Award, 2002

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3. What have been some of the most gratifying experiences in your investigational work?

I have always targeted my research toward better understanding and an improved clinical management of the glaucomas. My earliest research involved clinical studies of the families of glaucoma patients in an effort to better identify those individuals likely to develop glaucoma so that treatment could commence before visually significant damage occurred. Begun around 1960, the Collaborative Glaucoma Study evolved in part from family studies such as I have described, and it was the grandfather of multicenter clinical National Eye Institute glaucoma studies that have answered many diagnostic questions and improved glaucoma treatment.

The two most important medical glaucoma agents in history—the beta-blockers and prostaglandin analogues—were developed in the last 30 years. Beginning with Cairns' trabeculectomy and the use of fibroblast inhibitors, better surgical procedures have revolutionized the surgical management of these diseases, and laser glaucoma procedures (also approximately 30 years old) continue to improve. I have had the good fortune to be a part of the clinical investigations of many of these agents and surgical procedures.

I believe that advances in the next 25 years will be equally dramatic. I look forward to developments in gene therapy, optic nerve regeneration, and neuroprotection, to cite a few. As M. Bruce Shields, MD, predicted a few years ago, the treatment of glaucoma will eventually shift its focus from IOP to DNA.

4. What has been most rewarding about training ophthalmologists?

The most satisfying aspects of training ophthalmology residents and glaucoma fellows are observing their progress and following their careers. Having myself learned ophthalmology from some of our specialty's greatest teachers, I have always felt an obligation to pass on some of this knowledge to others. Even after leaving full-time academic medicine for private practice, I have continued to offer a fellowship in glaucoma. During my career, I have helped to train more than 75 subspecialists, and I, in turn, have learned from each of them. Although fewer residents now choose glaucoma as their subspecialty, I still get to work with some of the most competent, eager, and intelligent physicians in medicine.

5. What insights did you gain from leadership roles for various entities?

My involvement in a leadership capacity with organizations such as the AAO, AGS, ABO, and Missouri Society of Eye Physicians and Surgeons has taught me a great deal. The leadership of all these groups works hard to improve the delivery of the best possible eye care and to serve the membership—almost always for little personal gain. It is a labor of love for our profession, and I urge my colleagues to participate in the process.

I am still amazed that many leaders of residency training programs spend so little time and effort promoting ophthalmology and their state ophthalmological societies. Although the actual degree of support varies from state to state, the politics of medicine cannot be ignored. I am proud that the AGS first became involved in this area during my presidency. □