

CHALLENGING THE STATUS QUO

The IGC was founded to address obstacles in glaucoma care.

BY ARSHAM SHEYBANI, MD, AND ARIANA LEVIN, MD



PUSHING BOUNDARIES WITH THE IGC

Arsham Sheybani, MD

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 AGS 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 early in the disease course 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.

The Interventional Glaucoma Consortium (IGC) was founded in 2017 as a forum for progressive glaucoma specialists to exchange innovative

ideas and promote a proactive rather than reactive approach to patient care. The IGC promotes the concept that intervening early in the course of glaucoma requires a proper diagnosis of the disease and safer procedures. It brings together glaucoma specialists with varying opinions and empowers them to effect change.



A CALL TO ARMS

Ariana Levin, MD

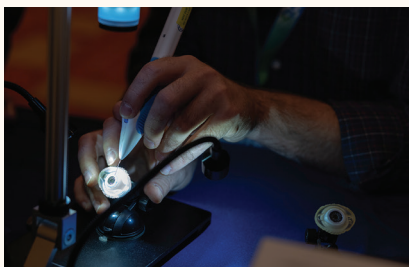
In 2022, I attended both the fellows program and the core meeting of the Interventional Glaucoma Consortium (IGC). Through these experiences, I was introduced to diverse approaches to glaucoma care and was challenged to imagine disease management 1, 5, and 10 years from now.

In a call to arms broadly applicable to all ophthalmology research, Matthew Schlenker, MD, FRCSC, 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, I attended a 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.

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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. 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, 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.

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