

Henry Jampel, MD, MHS

Dr. Jampel describes his long-term research goals, his approach to the management of concurrent cataract and glaucoma, and the influences on his life, professional and private.

What are the most challenging and rewarding parts of your job?

The greatest challenge is juggling its many components. Striving to be a good clinician while teaching, performing high-quality clinical research despite an increasing volume of patients, administering effectively, and fulfilling my other obligations to the ophthalmic community is difficult. The rewards, however, are multiple. Appreciative patients who are happy to learn that their glaucoma is highly unlikely to lead to blindness and students who decide to dedicate their careers to glaucoma or ophthalmology are two examples of particularly satisfying rewards.

What are the long-term goals of your research?

My aim is to determine what interventions are important for reducing vision loss from glaucoma, both in individual patients and in society. This effort includes a determination of what degree of glaucomatous damage leads to significant decreases in quality of life and function, how we can detect individuals at risk for this degree of glaucomatous damage, and, once detected, what form of management will minimize the likelihood that the patient's disease will worsen in a functionally important manner. To accomplish these goals, we need better detection in the community, an improved understanding of how glaucoma affects patients, and better treatments and means of evaluating outcomes.



What changes would you like to see in the surgical options for glaucoma?

No one disputes that we need a better operation to reduce the deleterious effect that the IOP has upon the optic nerve's function in our glaucoma patients. An honest review of the literature reveals that our standard procedure, trabeculectomy, has too many complications and not a high enough success rate. I believe, however, that

comparisons of the progress in cataract surgery to that in glaucoma surgery are unfair; the problems with glaucoma surgery are intrinsically more difficult. I have faith that a better understanding of the pathophysiology of the impairment of aqueous outflow will ultimately lead to more effective and safer procedures. In the meantime, we can be proud that trabeculectomy is safer and more effective than in the past, that we have demonstrated an important role for aqueous drainage devices, and that many smart

people are approaching Schlemm's canal and the suprachoroidal space as alternatives to the subconjunctival space.

What is your preferred approach to cataract in the presence of glaucoma and why?

It is hard enough to know how best to treat one disease, such as glaucoma. The management of concurrent disease, such as cataract and glaucoma, is particularly difficult. A

(Continued on page 44)

FAST FACTS

- Odd Fellows and Rebekahs professor of ophthalmology, Wilmer Ophthalmological Institute, Johns Hopkins University School of Medicine, Baltimore, 2006 to present.
- Medical director of the Wilmer Eye Institute at Greenspring Station in Maryland, 2005 to present
- Associate editor-in-chief of *Ophthalmology*, 2003 to present
- Recipient of the AAO's Senior Achievement Award (2008), Secretariat Award (2007), and Honor Award (1998)
- Recipient of Research to Prevent Blindness' Physician-Scientist Award, 2002
- Principal Investigator, Early Detection of Glaucoma Damage (NEI EY 12295-03), 2000 to 2005
- Co-investigator, Method for Glaucoma Screening in Primary Care Offices (EY016133), 2005 to 2008
- Principal Investigator, Treatment of Coexisting Cataract and Glaucoma (AHRQ contract 290-97-0006), 1999 to 2000

(Continued from page 46)

cardinal principle is making sure that one optimally deals with the potentially blinding disease, glaucoma.

Because I believe that trabeculectomy alone is more effective at lowering IOP than a combined procedure, I will often leave a visually asymptomatic cataract and perform a trabeculectomy alone if maximal lowering of the IOP is paramount. I realize that the odds of the patient's subsequently needing cataract extraction are high. On the other hand, in a stable glaucoma patient with cataract, I will often recommend cataract surgery alone. My choice is buoyed by the extensive recent literature suggesting that cataract surgery alone is not likely to worsen IOP control but seems to have a mildly beneficial effect.^{1,2}

"Because our surgical techniques continue to evolve, it is unlikely that I will have the same philosophy in 5 years."

The one thing that I am certain about is that, because our surgical techniques continue to evolve, it is unlikely that I will have the same philosophy in 5 years.

What factors have influenced your outlook on your life inside and outside of ophthalmology?

My father, Robert Jampel, MD, provided me with my first exposure to medicine and ophthalmology, and he has always given me excellent advice (eg, try to do your residency at Wilmer, choose glaucoma, etc.). He continues to be a role model as an academic ophthalmologist. My colleagues at Wilmer, the only ophthalmologic home that I have known, and particularly Harry Quigley, MD, my mentor for the past quarter of a century, have determined the way that I approach the mix of clinical care, research, and service that is my job. My wife, Risa, a dermatologist, and our three children provide a counterbalance to the demands of my career, and they always help me to put things in perspective. Finally, the unusual combination of a lifelong pursuit of endurance athletics, including the Ironman Triathlon World Championship, punctuated by a nearly life-ending sudden cardiac arrest certainly influences who I am today. □

1. Jampel H, Lubomski L, Friedman D. Treatment of coexisting cataract and glaucoma. (Prepared by Johns Hopkins University Evidence-based Practice Center under contract No. 290 97 0006.) AHRQ Publication No. 03-E041. Rockville, MD: Agency for Healthcare Research and Quality; June 2003.

2. Poley BJ, Lindstrom RL, Samuelson TW. Long-term effects of phacoemulsification with intraocular lens implantation in normotensive and ocular hypertensive eyes. *J Cataract Refract Surg*. 2008;34(5):735-742.