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The ophthalmic community is full of people dedicated to serving humanity in the manner that best fits their abilities. As a clinician scientist, my service takes two forms: (1) caring for individual patients and (2) generating and disseminating knowledge that will let the next generation of ophthalmologists care for patients better than I could ever imagine. This is a rare opportunity, and I am humbled to have it bestowed upon me.

We glaucoma specialists seek to minimize suffering and maximize the quality of life of our patients, but are we really doing all we can toward this end? My research has demonstrated that individuals with bilateral moderate/severe glaucoma have likely stopped driving, have a significant fear of falling, and read more than 50 words per minute slower than normal. I have observed how these same individuals behave in their normal lives using accelerometers and cellular tracking devices, and I have found that they are more homebound and perform one-third as much physical activity as individuals with normal sight. These findings paint a vivid picture of how our patients with glaucoma are affected.

How are we addressing these problems? We are doing an admirable job of preventing individuals under our care from reaching more advanced stages of disease and disability, but we are doing close to nothing to rehabilitate those unfortunate enough to have reached advanced stages of disease. Indeed, a PubMed search for *glaucoma* and *quality of life* generates 210 articles, but a clinicaltrials.gov search of *glaucoma* and *rehabilitation* turns up two clinical trials, neither of which has told us yet how to improve quality of life in glaucoma. Not surprisingly, rehabilitation has not become a part of our treatment of glaucoma. Only now do we clearly understand which glaucoma patients are disabled and the specific ways in which they are disabled. Still, even when we recognize that disability in a patient, we do not always know how to rehabilitate him or her, have access to the resources to help us initiate rehabilitation,

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or have faith that rehabilitation is likely to succeed. As a clinician scientist, these are not merely problems to me but rather challenges to be overcome with scientific study.

To my delight, my 6-year-old daughter recently decided that she would rather be a scientist than a princess upon growing up. She was quite confused, however, when I professed that I was a scientist. To her, I was a doctor who saw patients with eye problems and performed surgery, not someone who conducted cool experiments like mixing elemental sodium and water to create fire and explosions. My 9-year-old son was smart enough to ask me what experiments I did, and I replied that my colleagues and I were testing whether patients with glaucoma walked less. His response of complete silence clearly indicated this was not as impressive as creating fire and explosions through chemical reactions. He may be correct, but if I can help develop rehabilitative strategies to decrease patients' disability and suffering from glaucoma, I will settle for functional over cool. ■

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