

OPPORTUNITY KNOCKS



The glaucoma community recently entered an exciting period in its history. For years, innovative ophthalmologists have discussed the possibility of more minimally invasive and promising transformative glaucoma surgical alternatives in an almost fairy-tale manner. Skeptics have been understandably cautious regarding potential advances and,

at times, almost dismissive of them. After all, excitement over technologies such as the holmium laser certainly harmed many glaucoma patients in the past.

With physicians' trust in the value of trabecular bypass and micropulse diode laser procedures slowly growing, however, interest in the surgical management of glaucoma is at an all-time high. Micropulse cyclophotocoagulation treatments have now been performed in more than 25,000 patients (data on file with Iridex). Options for microinvasive glaucoma surgery continue to expand. With the impressive safety profile of the iStent Trabecular Micro-Bypass Stent (Glaukos), the availability of numerous other trabecular bypass procedures, and the recent launch of the CyPass Micro-Stent (Alcon), comprehensive ophthalmologists are becoming increasingly inclined toward early surgical intervention to manage glaucoma. Drug delivery systems in development will likely drive more aggressive interventional treatment of glaucoma into the optometric community as well.

What does this rapid evolution and the fact that most glaucoma patients are under the care of optometrists or comprehensive ophthalmologists mean to fellowship-trained glaucoma subspecialists? Will we be relegated to the management of patients with complex and end-stage glaucoma who require filtration surgery or a tube shunt? Will we lead the charge in educating clinicians on how to implement innovative glaucoma therapeutic modalities in practice? Will we come beside our comprehensive colleagues to encourage and support them when complications occur, or will we criticize and condemn them for using the newest procedures?

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I believe that it is in our best interest not only to embrace but also to guide the paradigm shift in glaucoma management. The train has left the station, and it is not turning back. This does not mean that all new technologies will fulfill our expectations or even be in the best interest of many glaucoma patients. To fight advances on this front, however, will only marginalize the glaucoma community and increase the chances of surgical complications with newer devices. By being relatively early adopters and by prompting the rigorous scientific evaluation of promising new technologies and surgical techniques, we will gain credibility among our colleagues as leaders in the field.

As a community steadfastly committed to the future of our profession and to our patients, we have a responsibility to help shape the future of glaucoma care. The rewards if we do so will be great for patients. ■

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