

New Surgical (and Now, Nonsurgical) Options Allow for Best Patient Care

Surgery is a topic that is close to the hearts of most retina specialists. In this issue of *Retina Today*, we cover a range of surgical topics—new options in illumination, endoscopy, chromovitrectomy, and optical coherence tomography-guided surgery, among others. In addition, several of our regular columns feature surgical discussions. Members of the Vit-Buckle Society share their opinions on best techniques in the repair of giant retinal tears in *Surgical Updates*. In part 2 of the *Fellows' Focus* section, new attendings discuss some of the important things that they learned in their vitreoretinal fellowship programs and how these have helped them transition into their current positions.

Whether we are new surgeons or veterans who have been in ORs for decades, we are always striving to improve our techniques and are eager to try the newest technologies that are designed to aid in this effort. Although part of this passion is fueled by the sheer challenge of the delicate maneuvers that we perform in surgery, as physicians we are driven by the pledge to our patients to provide the best outcomes possible, using the best mode of treatment available. The best treatment, as we all know, is not always surgical.

A few weeks ago, Wills Eye Hospital and Mid Atlantic Retina in Philadelphia had the opportunity to be one of the first centers to inject the newly US Food and Drug Administration-approved pharmacologic agent Jetrea (ocriplasmin, ThromboGenics), which is indicated for the treatment of symptomatic vitreomacular adhesion.

My (ACH) first patient to receive the injection that morning was a retired police officer who presented with a small macular hole that had brought his vision down to 20/100 in his right eye, and he described distinct visual disturbances. Prior to the availability of ocriplasmin, I would most likely have operated on this patient, but he was a perfect can-

didate for this less-invasive pharmacologic option, both because his macular hole was small (patients in the clinical trials with macular holes ≤ 250 μ m and vitreomacular traction with adhesion < 1500 μ m had the best outcomes) and because he shared with me that he has a vacation in Aruba planned in February. When I told him that there was a new drug available that might be able to help close the hole without surgery, eliminating the inconvenience and morbidities of surgery, and obviating the need for a gas bubble and facedown positioning that would interfere with his air travel plans, he was enthusiastic. "Let's do this," he said.

Ocriplasmin, like any medication, is not 100% guaranteed to work in all patients. We know from the clinical trials that patient selection is key to successful outcomes. As with any procedure, surgical or medical, it is critical to carefully weigh the risks and benefits and to discuss all options with the patient.

In the case of my first patient, the retired police officer, ocriplasmin was a success. At day 2 postinjection, his macular hole began to close, and his vision had improved to 20/80. At day 9, his vision was 20/60. I'm expecting a further improvement with time.

We are surgeons, and we like to do surgery when it's indicated. This agent is not for all cases, of course, and I do not think that it will take away significantly from our surgical caseload. Its availability, rather, allows us to help patients who might not be candidates for surgery—those whom we previously would have observed. For my patient, who will be flying to Aruba this month, ocriplasmin is a game changer. ■



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