A CAN-DO ATTITUDE


We have been talking a lot about how much our specialty has changed over the last few decades. In less than 20 years, we went from little to no therapeutics for our wet AMD and diabetic eye disease patients to a plethora of options—so many, in fact, that many of us have a bigger refrigerator on our wish lists.

With all the hubbub surrounding the rapidly expanding therapeutic landscape, it can be easy to overlook innovation in the OR. Today's surgical suite is significantly more high-tech with the advent of 3D heads-up displays, intraoperative OCT, smaller-gauge vitrectomy, and advanced tools. That's why we prefer to kick off the new year with an issue dedicated to our roots—surgery.

Don't get us wrong, these innovations are wonderful to have, but what matters most in the OR is the surgeon. With the right skillset and a willingness to think outside the box at times, surgeons can work wonders. We all love hearing success stories in which a patient faced with the possibility of blindness ends up with 20/40 vision postoperatively. When those cases are discussed at the podium, the presenter more often than not says something like, "I had heard about this technique from a colleague and decided to give it a try." That willingness to try new approaches is what hooked many of us in residency and fellowship.

Perhaps nowhere is this innovative mindset more apparent than with secondary IOLs and macular holes.

In this month's roundtable article (and podcast!), Christina Y. Weng, MD, MBA; Ashkan M. Abbey, MD; María H. Berrocal, MD; and Omesh P. Gupta, MD, MBA, discuss their preferred techniques for secondary IOL rescue/repair, as well as tips, tricks, and challenges. Note that they all have a *preferred* technique, and they all have tried each other's varied methods. None of them handle a secondary IOL in the exact same way, and yet all four of these surgeons have incredible outcomes. They are also tweaking their techniques as they go. Dr. Berrocal, for example, likes the modified Yamane technique, but she puts her own twist on it to save time and reduce both complications and surgical waste—what she likes to call the abbreviated modified Yamane.

The same can be said for macular hole surgery these days—no two patients are alike, and neither are our surgical approaches. Also in this issue, Sophie J. Bakri, MD, shares a rundown of the many ways we can treat macular holes, including internal limiting membrane flaps, autologous platelet-rich plasma, human amniotic membrane, macular hole plugging, autologous neurosensory retinal flaps, and macular buckling. The right treatment approach depends on each patient case and the surgeon's comfort with various techniques. These cases also push surgeons to try new methods and materials, particularly when a tried-and-true surgical approach just isn't getting the hole to close.

What makes these advances and updated surgical techniques so much fun (other than improving patient outcomes, of course) is the fact that we collaborate with each other to make them happen. We love to share success stories, examine intra- and postoperative complications, discuss new surgical approaches, and learn from each other. It's no surprise that we have so many meetings with surgical video contests, case-based sessions, and panels. If retina specialists are known for anything, it's that we are never afraid to expand our surgical armamentarium.

Look through this issue, and we can guarantee you will want to try a few of these tricks the next time you have a tough case in the OR. ■


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ALL THINGS MEDICAL

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Collaboration is crucial when you're stumped with a tough case.
By Cassie Ludwig, MD, and Nimesh A. Patel, MD

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High-quality fundus imaging and aggressive treatment of inflammation is critical for children with retinal vasculitis.
By Dilraj Grewal, MD

The Case of the Enormous Blind Spot
Learn to diagnose acute idiopathic blind spot enlargement.
By Zurab Glonti, MD; Shalva Skhirtladze, MD; and Giorgi Mekvabishvili, MD