DEBRA A. GOLDSTEIN, MD

WHY DID YOU DECIDE TO FOCUS ON UVEITIS MANAGEMENT?

I was lucky enough to train in a residency program with a uveitis specialist, so I was exposed to the field early in my training. I loved the fact that I could use my newly learned skills in medicine, considering the patient's systemic symptoms and signs, in the formulation of a differential diagnosis. I still love that part—getting to play detective to come up with a diagnosis. The field really fits with my personality. I also love that I see patients of all ages— about 20% of my practice is pediatric—and that I get to follow patients often enough to get to know them. I probably would have been happy in any of a number of fields, but I really love being a uveitis specialist.

HOW HAS THE US FDA APPROVAL OF A NONCORTICOSTEROID IMMUNOMODULATORY AGENT CHANGED THE TREATMENT MAP FOR PATIENTS WITH NONINFECTIOUS UVEITIS?

We have used noncorticosteroid treatment for uveitis for decades. Methotrexate, for example, has been used to treat rheumatologic diseases since the 1960s and received FDA approval for the treatment of rheumatoid arthritis in the 1980s. The first report of its use to treat ocular inflammatory disease was in 1965.

However, until adalimumab (Humira, AbbVie) was approved by the FDA to treat noninfectious intermediate, posterior, and panuveitis in 2016, there was no systemic therapy specifically labeled for the treatment of uveitis. Despite the fact that antimetabolites such as methotrexate and mycophenolate and biologics such as adalimumab and infliximab (Remicade, Janssen) are commonly used to treat uveitis, adalimumab is still the only agent approved by the US FDA for this indication. All other systemic therapies for uveitis are used off-label.

I have a very low threshold for starting systemic immunomodulatory therapy in patients with uveitis, and I consider it for anyone with chronic disease requiring long-term therapy. In general, for disease that is not immediately sight-threatening, I start with an antimetabolite. If this is inadequate, my second-line therapy is adalimumab. I choose this agent over the other biologics as it has FDA approval, and it is therefore easier to get insurance approval for this drug compared with the other biologic agents.

WHAT LED YOU DOWN THE PATH OF ACADEMICS RATHER THAN PRIVATE PRACTICE?

I realized early in the course of my residency that I love caring for patients in a collaborative teaching environment, so the decision to pursue a career as an academic physician was quite simple for me. I was excited to be able to mentor future generation of clinicians, although I did not realize at the time I chose this path how much I would continue to benefit personally from these interactions. I mentor fellows from the United States as well as many other countries, and continue to learn from my fellows on a daily basis. I also have wonderful colleagues in ophthalmology with whom I can discuss challenging patients, and colleagues in other specialties who provide clinical perspectives outside the field of ophthalmology. This is certainly possible in private practice, but it is easier to attain in an academic setting.

Debra A. Goldstein, MD, and her husband, David Cohen, MD, in Seoul, South Korea, in November 2018, when Dr. Goldstein attended the Korean Uveitis Society meeting as a guest speaker.

AS AN EDUCATOR, WHAT PEARLS DO YOU HAVE FOR YOUNG RETINA SPECIALISTS HANDLING THEIR FIRST FELLOWS?

It is easy to be intimidated when one is first given the responsibility of teaching. I have always felt that honesty is the best policy, especially admitting when you don't have all the answers. Maybe it's because almost 50% of uveitis is idiopathic, but I'm pretty comfortable with the phrase "I don't know."

One of the most important things that we can do as mentors is to be good role models. I try to model how to care for patients, as well as how to teach, as many of my fellows go on to academic practice themselves. I try always to be available for my patients, as well as for my fellows, modeling the teacher and clinician that I hope that they will become.

WHAT ARE THREE WORDS THAT DESCRIBE YOU?

Passionate, energetic, demanding. ■

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