



VBS and *Retina Today*: A Continued Partnership



The Vit-Buckle Society (VBS) and *Retina Today* have had a special relationship since the VBS first convened in a formal setting in 2013. We invited the publication to cover that inaugural meeting. They embraced the VBS's tone of candor, support, and curiosity (all while not taking ourselves too seriously), and collaborated with our founding members to chronicle the meeting.

That collaboration continues in this year's *Retina Today* surgery issue. When the editors invited the VBS to host a suite of articles that reviewed the events of the 2020 VBS virtual meetings, we couldn't say no. Continuing the mutual relationship between these two entities was a natural fit—and was one of the things that was unchanged during the COVID-19 era.

The COVID-19 pandemic has forced plenty of change in the field, and the VBS is proud that it has adapted to the conditions for hosting educational meetings. In this series of articles, you'll see that, although the 2020 VBS meetings have gone virtual, the quality of discussion remains at an all-time high.

—R. Ross Lakhanpal, MD
President, Vit-Buckle Society



Scleral Buckling Pearls



An Interview With Ajay E. Kuriyan, MD, MS, by Brian K. Do, MD

In Part 2 of the Vit-Buckle Society's Virtual Series, Ajay E. Kuriyan, MD, MS, imparted innumerable scleral buckling pearls. With residents, fellows, and fully trained surgeons who may not be comfortable with certain aspects of scleral buckling in mind, Dr. Kuriyan provided tips and tricks from start to finish that any one of us could find valuable.

Although scleral buckling has declined in popularity with the emergence of vitrectomy, it certainly still has a role in the vitreoretinal surgeon's armamentarium. In his presentation, Dr. Kuriyan listed a number of reasons to consider buckling in the repair of rhegmatogenous retinal detachments:

- They provide support of the vitreous base when used in conjunction with vitrectomy;
- They offer potential for avoiding unnecessary intraocular surgery;
- There is a high reattachment rate; and
- There are lower rates of retinal displacement with buckling compared with intraocular surgical options.

Below is an edited version of my interview with Dr. Kuriyan, followed by my notes on additional points that he made.

Brian K. Do, MD: Where do you see most people struggle as they're getting started with scleral buckling? What tips can you offer these folks?

Ajay E. Kuriyan, MD, MS: Whenever I adopt a new technique, I start by making a surgical checklist for supplies and intraoperative steps. I try to reach out to a surgeon experienced with the technique, if possible, to review my plan and help me anticipate any complications and understand how to manage them. Being as prepared as possible always helps me feel better about trying something new.

Another important factor is patient selection. Try to select patients with perfect views and easy-to-visualize breaks initially. If you're less comfortable with cryopexy, using

chandelier illumination and visualizing the break under the surgical scope may be helpful.

Dr. Do: One of the interesting things you propose is that we consider performing cryopexy before prepping and draping the eye. What are the advantages of making this change to the usual surgical sequence?

Dr. Kuriyan: I have to thank my colleague, Michael N. Cohen, MD, for introducing me to this technique. I like this technique because the fundus view is the best it will be all case, it's easy to manipulate the patient's head position, there are no concerns for contamination, you can put the indirect on yourself and manipulate it without baggies, you

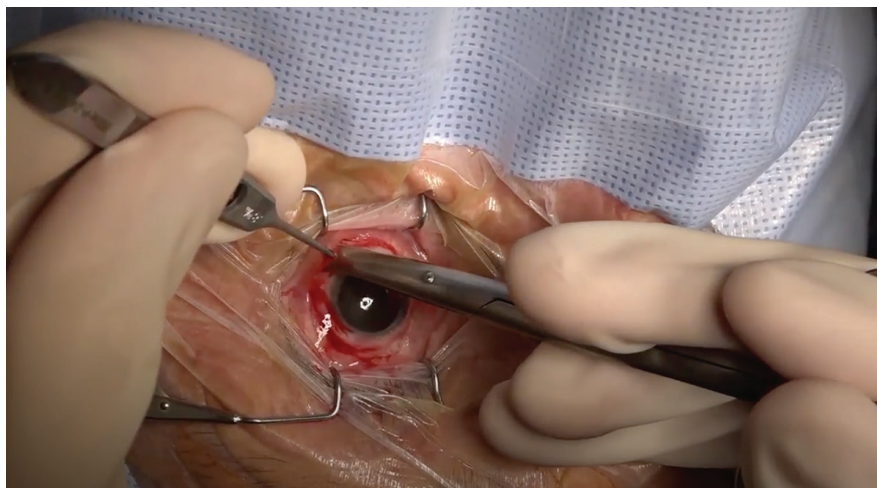


Figure 1. During scleral buckle surgery, isolation of rectus muscles helps to avoid muscle splitting and diplopia.

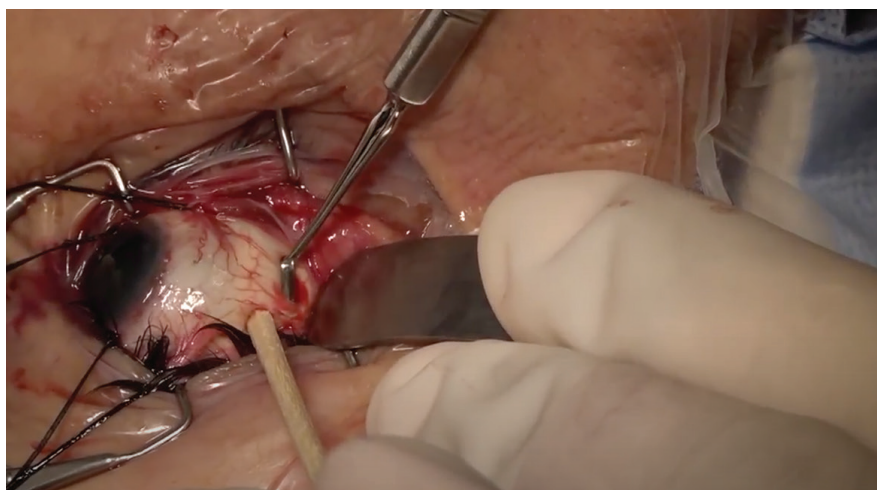


Figure 2. Use of belt loops for securing an encircling band during scleral buckle surgery is a preference of Dr. Kuriyan.

can use lenses that haven't been damaged during sterilization, and you're more comfortable and less prone to overheating when you're not wearing the surgical gown.

Dr. Do: Have you ever seen anyone use belt loops with an encircling element larger than a No. 41 band?

Dr. Kuriyan: Yes, I have used it for a No. 42 as well. You just need to make your belt loops longer from anterior to posterior. If you have very posterior pathology that you're trying to support with the band, this may be harder, but you can do it for most cases. Pulling the band on both sides of the belt loop—like stretching a rubber

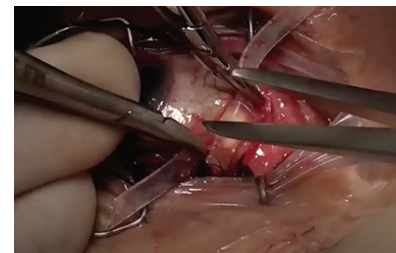
band—makes it thinner and easier to pass through a tight belt loop, if you didn't make it long enough.

Dr. Do: How do you decide in which cases drainage is appropriate?

Dr. Kuriyan: I usually don't drain if the break can be supported by a gas bubble or if there's only shallow fluid, to eliminate the risk for any sub-retinal hemorrhage. If there is a break that cannot be supported with a gas bubble, especially if the detachment is bullous or chronic, I tend to drain.

Dr. Do: How do you decide which eyes get a gas bubble and why?

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Scleral Buckling Pearls

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Dr. Kuriyan: If the break can be supported by a gas bubble, I usually use it to hasten the resolution of the fluid. Part of this is driven by the desire not to drain in those patients in order to decrease the risk of sub-retinal hemorrhage that extends to the macula. It's a rare complication but can potentially have a profound negative impact on the patient's post-operative vision.

Tenon Dissection and Isolation of Rectus Muscles

Dr. Kuriyan stressed that, when performing dissection of Tenon capsule and isolation of the rectus muscles, it is important to ensure visualization of bare sclera on either side of each muscle (Figure 1). Effective muscle isolation is vital to avoid splitting muscles and, secondarily, to prevent diplopia.

Marking the Break

Dr. Kuriyan recommended double-checking the mark or marks by depressing the area of the marks under direct visualization.

Element Selection

Dr. Kuriyan prefers the No. 41 band, which can easily be sutured or fixated to the sclera via belt loops. There are, of course, many other encircling elements that can be used. Both the No. 240 and No. 41 bands can be used with both symmetric and asymmetric "tire" elements. The No. 240 band can similarly be fixated using the belt-loop method (Figure 2).

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Pars Plana Vitrectomy Versus Medical Treatment for Proliferative Diabetic Retinopathy



An Interview With María H. Berrocal, MD, and Yasha S. Modi, MD, by Avni P. Finn, MD, MBA, and Basil K. Williams Jr, MD

In Part 3 of the Vit-Buckle Society's Virtual Series, María H. Berrocal, MD, and Yasha S. Modi, MD, discussed the pros and cons of early vitrectomy versus medical therapy for patients with high-risk proliferative diabetic retinopathy (PDR). Dr. Berrocal outlined the advantages of early vitrectomy in patients with PDR, including lifting the hyaloid, which can act as a scaffold for neovascularization and traction. Dr. Modi discussed why a more conservative approach combining panretinal photocoagulation (PRP) and anti-VEGF therapy may pose less risk to the patient and potentially be just as efficacious.

Avni P. Finn, MD, MBA: Dr. Berrocal, what is your initial treatment for a patient with high-risk PDR?

María H. Berrocal, MD: I choose my initial treatment depending on whether the posterior hyaloid is completely detached or not. If there is a complete posterior vitreous detachment (PVD) and macular edema, I begin with anti-VEGF injections and add PRP later. If there is a complete PVD and no macular edema, I treat the patient with PRP up to 2 to 3 disc diameters (DD) from the arcades. If the hyaloid is not completely detached, particularly if there is vitreous hemorrhage or areas with fibrovascular proliferation, I usually offer vitrectomy. I explain the risk of progression with occurrence of tractional retinal detachment (TRD) and the benefits of long-term stabilization after vitrectomy with hyaloid removal. If the patient does not want surgery and has no diabetic macular edema (DME), I perform PRP as above. If the patient has associated DME, I start PRP inferiorly and concomitant anti-VEGF therapy and complete the PRP in two to three sessions. Subsequently, I treat the edema with anti-VEGF therapy, stressing the importance of compliance with appointments.

Basil K. Williams Jr, MD: What about you, Dr. Modi?

Yasha S. Modi, MD: My initial approach is combination anti-VEGF therapy and PRP, but even more important is the initial discussion with the patient regarding the severity of the disease, the likelihood of blindness in the absence of treatment, and the importance of *regular* follow-up to prevent severe complications. All first-visit patients in my clinic must agree and "sign" a verbal contract with me. I state, "I promise I will do everything possible to make sure you see for the rest of your life. However, you must promise me you will *never* miss an appointment with me or your primary care doctor or endocrinologist." This small act of verbal commitment combined with tracking of patients through the electronic health record system has lowered my rate of loss to follow-up, which is where devastating ocular complications may occur.

When opting for combination PRP and anti-VEGF therapy over surgery, it's important to realize that this is *my* framework that I apply across the majority of my patients but not necessarily *all* patients. As clinicians, we have to gauge the likelihood of disease progression with the implemented

therapy with a readiness to pivot to surgery if the disease were to worsen (eg, progressive contraction of fibrovascular membranes with worsening traction). We must also gauge the likelihood of the patient's compliance with return visits.

Dr. Finn: Dr. Berrocal, when do you consider early PPV for PDR?

Dr. Berrocal: I consider early vitrectomy in the following scenarios: eyes with attached hyaloid, severe disease with vitreous hemorrhage or areas of fibrosis, fibrovascular fronds, or TRD; patients who are poorly controlled or have concomitant renal involvement and hypertension; and patients who exhibit poor compliance or are at risk of losing insurance. If it is the patient's first visit, I perform a fluorescein angiogram to show the pathology, talk about surgery, give the patient educational pamphlets, and start PRP in the periphery. The patient returns in 2 to 4 weeks to continue the conversation. Eyes with the above characteristics can quickly progress to TRD despite PRP (Figure).

Dr. Williams: Dr. Modi, what research guides your decision of whether to start with anti-VEGF therapy and PRP?

Dr. Modi: What makes high-risk PDR management so difficult is that we lack high-quality randomized clinical trials to guide decision-making. The DRCR Retina Network's Protocol S was a landmark study that evaluated the initial treatment strategy for PDR with anti-VEGF therapy or PRP (with rescue anti-VEGF for DME).¹ However, only 1% of patients enrolled in that protocol had high-risk PDR with a diabetic retinopathy severity score of 85 (presence of preretinal or vitreous hemorrhage at presentation) or worse.

Thus, when we encounter patients with high-risk PDR, we must turn our attention to another well-executed multicenter randomized clinical trial called the PROTEUS study, which evaluated combination PRP plus anti-VEGF therapy versus PRP alone for initial management of high-risk PDR.² Regression of neovascularization at 1 year was seen in 93% of patients receiving combination PRP and anti-VEGF therapy, compared with 71% of those receiving PRP alone. Progression to surgery was seen in 2.5% of patients in the combination group and 11% in the PRP group, indicating three things:

1. A combination approach is superior to PRP alone;
2. the vast majority of patients managed initially with conservative measures did well; and
3. a small percentage of patients will still require surgery despite intensive PRP and anti-VEGF therapy.

These data provide me a reasonable framework to start with initial therapy of combination PRP with anti-VEGF therapy for these high-risk patients.

Dr. Finn: Dr. Berrocal, you presented some strong evidence for early vitrectomy with your own case series of

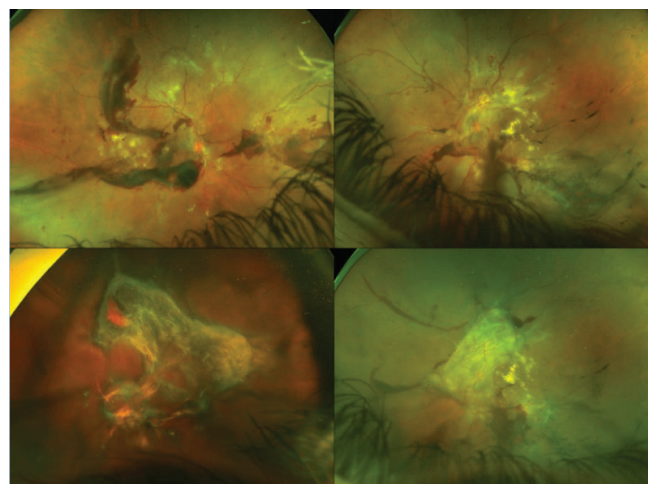


Figure. Rapid progression to TRD in both eyes can be seen in a patient with PDR who was at high risk of developing TRD. Development occurred in 8 weeks OD and 3 weeks OS during a clinical shutdown due to COVID-19.

60 patients who had PPV in one eye and PRP in the other eye. In these patients, 8% of eyes that had PPV ended up with hand motions (HM) or worse VA, whereas 36% of eyes treated with PRP had HM or worse VA. Similarly, series of patients treated with anti-VEGF therapy alone often show that lapses in follow-up due to illness, financial hardship, or noncompliance lead to poorer outcomes.^{3,4} Can you elaborate on what you see as the advantages of early PPV for PDR?

Dr. Berrocal: The advantages of early vitrectomy in PDR are most notable in eyes with a totally or partially attached hyaloid. Detaching the hyaloid during surgery removes the scaffold for neovascularization and prevents TRD or combined rhegmatogenous and TRD, as well as reducing the risk of macular edema, macular hole, and vitreomacular traction. With early vitrectomy we avoid the main complications of PDR that cause visual loss, reduce the need for many follow-up visits, and stabilize the eyes long-term. During the procedure, I always do PRP to the ora and up to 2 to 3 DD from the arcades. In young patients, the risk of cataract progression is small, and the procedure is essentially curative. With advances in vitrectomy, early PPV is a relatively simple procedure with minimal complications, and it is cost-effective to the patient and society. The advantages of stable visual acuity and reduction of the number of physician visits, time, and monetary costs are immense for individuals with diabetes.

Dr. Williams: Dr. Modi, what do you see as the drawbacks or potential risks of early PPV for PDR?

Dr. Modi: There is nothing better than beautifully executed diabetic surgery with total posterior hyaloid delamination that renders the patient stable in perpetuity. This is the goal for all surgeries, and we are fortunate as retina specialists

to execute to this standard in the majority of cases given recent technological advancements. However, some potential drawbacks occur when even small complications such as a retinal break balloon to proliferative vitreoretinopathy superimposed on PDR. One study reported retinal breaks in diabetic surgery in 4% of patients receiving 23-gauge PPV.⁵ Additionally, in cases in which the surgeon may not be able to achieve full delamination or when segmentation is incomplete, reoperation rates may be unacceptably high.

Finally, each surgical case poses interesting technical challenges, and each surgeon has unique skills and limitations. Thus, it is incumbent on each retinal surgeon to appraise each situation and calculate his or her own risk when considering surgical intervention as the first-line approach. ■

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Buckle Fixation

Scleral passes for buckle fixation are an art in and of themselves, and trainees should focus on getting comfortable with the associated ergonomics. Dr. Kuriyan said he prefers placing the band under the muscles before suture fixation, as opposed to preplacing the sutures, but the procedure can be successfully completed either way.

In the creation of belt loops, the partial-thickness radial scleral incisions can be made using Dr. Kuriyan's preference, which is a No. 64 Beaver blade (Beaver-Visitec International), or a guarded diamond blade or crescent blade. The partial-thickness dissection can then be performed using either a Castroviejo scleral dissector or a crescent blade. For performing this step, the use of a cotton-tipped applicator or other blunt instrument for globe fixation can be helpful.

Sleeve Placement and Tightening the Buckle

A helpful tip Dr. Kuriyan shared in his talk is to pull down toward the globe with the first end of the encircling band placed through the sleeve so as to help make room for insertion of the other end.

Dr. Kuriyan reviewed some basic geometry that helped attendees to visualize his suggestions in regard to buckle tightening. These principles supported his suggestion to tighten the band by 11 mm lengthwise in order to achieve an additional 1.75 mm of radial indentation. This can be approximated by having locking needle drivers on each end of the encircling band and tightening the band until the measured distance between them has increased by 11 mm.

Conjunctival Closure

Dr. Kuriyan recommended closure with gut suture to reduce risk of granuloma formation and to provide overall improved comfort for patients. Burying sutures may be helpful as well. ■

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Pearls for a Scleral Pocket IOL Suturing Technique



An Interview With Gabriela LópezCarasa, MD, by Camila V. Ventura, MD, PhD

In Part 4 of the Vit-Buckle Society's Virtual Series, Gabriela LópezCarasa, MD, presented a secondary IOL implantation technique. The technique she elegantly described was one inspired by the technique of scleral fixation without conjunctival dissection to prevent suture erosion, originally described by Richard S. Hoffman, MD. In addition to Dr. Hoffman's scleral pockets, she integrated a cow-hitch knot to provide two-point fixation and prevent lens tilt.

Camila V. Ventura, MD, PhD: Please briefly describe the secondary IOL implantation technique you chose for this case (Video).

Gabriela LópezCarasa, MD: The first step is to create the scleral pockets. I start by making clear corneal incisions 180° apart using a diamond knife, which will facilitate proper final positioning of the IOL haptics. Then, scleral pockets are created extending 3 mm posteriorly from the clear corneal incision using a crescent blade (Figure 1).

After placing a 23-gauge infusion cannula, I create a 7-mm sclerocorneal incision, and sutures are preplaced in the wound prior to fixating the IOL to avoid hypotony.

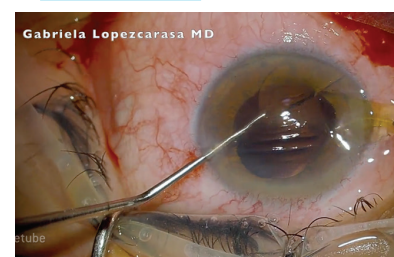
A 10-0 nylon suture and a 30-gauge needle are used to create sclerotomies 2 mm apart from each other in order to externalize the Gore-Tex CV-8

(polytetrafluoroethylene [PTFE], W.L. Gore & Associates) suture. The 30-gauge needle is used for docking the nylon suture, which is knotted at both ends to be used as a loop for placing the PTFE suture.

The PTFE suture is then pulled through the sclerotomy using the 30-gauge needle, 3 mm from the limbus. The nylon suture is externalized, either with a hook or forceps, to make a loop so that I can pull the PTFE suture out from the sclera with the nylon suture. The same steps are repeated for the other end of the PTFE suture.

For the cow-hitch knot, I use the same 10-0 nylon suture. First, both ends are passed through the eyelets of the IOL haptics. Then the PTFE suture is passed into the nylon loop and pulled through the eyelet to anchor the PTFE loop and create a two-point fixation knot on the haptics (Figure 2).

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Gabriela Lopezcarasa MD
Vitreous Hemorrhage, Retinal Tears, and Inferior Retinal Detachment.

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The IOL is then placed into the eye, and the sutures are pulled to position the IOL behind the iris and into the ciliary sulcus. My IOL preference for this technique is the one-piece CZ70BD IOL (Alcon), but an AcrySof MA60 IOL (Alcon) also works well.

After IOL placement, the PTFE sutures are retrieved from the scleral pocket with a Sinskey hook to externalize both ends, and a 3-1-1 knot is

made and placed under the scleral pocket roof. Finally, the sclerocorneal wound is closed.

Dr. Ventura: What are the potential advantages and pitfalls of this technique?

Dr. LópezCarasa: The most significant advantage of the scleral pocket technique is the reduction of surgical time because there is no need for conjunctival dissection and scleral flap creation. The technique also avoids the induced astigmatism usually observed with a scleral flap technique. Moreover, by creating scleral pockets you prevent exposure and erosion of the suture, reducing the incidence of IOL displacement, luxation, and endophthalmitis.

The biggest pitfall with this technique is the possibility of not forming the scleral pockets correctly in size, depth, and length. This initial step requires attention and precision to avoid complications such as perforation of the sclera, bleeding, creation of a superficial scleral pocket, and malpositioning of the IOL.

Dr. Ventura: What pearls can you offer for making this technique go as smoothly as it appears in your video?

Dr. LópezCarasa: My suggestions are as follows:

- Review the technique and watch surgical videos to get yourself ready for surgery.
- Before you begin the surgery, make sure you have everything you need handy, including a diamond knife, crescent blade, 30-gauge needle, 10-0 nylon and PTFE sutures, and a Sinsky hook.
- The depth of the clear corneal incision must be between 300 and 400 μ m.
- As you create the scleral pocket with the crescent blade, make sure you dissect the sclera moving the blade from side to side in a downhill movement.
- Avoid creating the scleral pockets at the 3 and 9 clock positions to prevent damaging the long posterior ciliary arteries.
- The scleral pockets should be at least 3 mm long to position the IOL behind the iris and in the posterior chamber.
- When you perform the sclerotomies to externalize the PTFE sutures, make sure the sutures traverse the pockets before continuing with the procedure.
- Using a 30-gauge needle to perform the sclerotomies, you will prevent leakage.

Dr. Ventura: Why do you choose this technique over others, or are there certain circumstances in which you like it better?

Dr. LópezCarasa: I want to emphasize that the best surgical technique is the one that works for you. That being said, I think this is a very sophisticated technique for secondary IOL



Figure 1. A crescent blade is used to create scleral pockets 3 mm from a clear corneal incision.

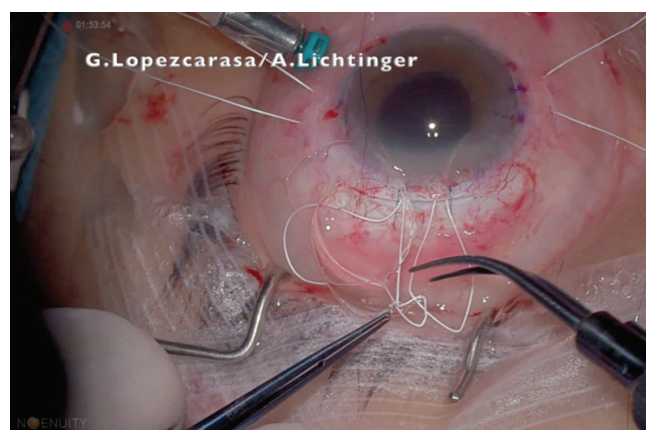


Figure 2. For the cow-hitch knot, both ends of the nylon suture are passed through the eyelets of the IOL haptics. Then the PTFE suture is passed into the nylon loop and pulled through the eyelet to anchor the PTFE loop and create a two-point fixation knot on the haptics.

implantation. Although I consider it challenging, great results can be achieved if you train and practice enough. Given that it prevents suture erosion and provides outstanding stabilization for the IOL, this technique can yield excellent visual results for patients without capsular support. ■

Dr. LópezCarasa wishes to thank Alejandro Lichtinger, MD, for educating and assisting her on the surgery discussed in this article.

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Practice-Building Pearls for New Associates



An Interview With Nika Bagheri, MD, by Kyle D. Kovacs, MD

During Part 4 of the Vit-Buckle Society's 2020 virtual meeting, Nika Bagheri, MD, delivered an insightful presentation on practice-building recommendations for new vitreoretinal surgeons. In her talk, Dr. Bagheri suggested a number of pearls, ranging from the knowledge new associates need to ascertain (practice-specific systems, the referral landscape, partner strengths, knowing your staff), to actionable items (having face-to-face meetings with referring providers, covering all emergencies from said providers, and being available to do so), to attitudes new associates need to maintain (balancing patient expectations, surviving poor reviews, and remembering that even young associates bring something to the table).

Kyle D. Kovacs, MD: You are more than 2 years into your practice development. How have you shifted your practice-building mentality from day 1 to today?

Nika Bagheri, MD: I think that we perform best when we have a fluid and flexible approach, but practice building never ends, and certain principles are key to follow whether it is your first day on the job or your 20th year in practice. Namely, the three A's: Be *available*, *affable*, and *able*. Every referring doctor experience, from a simple phone call to a dictated letter, is an opportunity to demonstrate to your community that you are a AAA-certified physician, so to speak.

Dr. Kovacs: In your VBS presentation, you touched on one of the hardest balancing acts for young practitioners: doing what patients *want* versus providing what patients *need*. What tips or tricks do you have for new associates?

Dr. Bagheri: The vast majority of patients simply want to feel that they are cared for, respected, and safe in trusting

a competent physician. I like to set expectations early and review exam findings in detail at the end. Always try to frame things in an appropriate way to give reassurance where it's warranted, without minimizing the reason the patient came in. Having spiels for diagnosis, prognosis, and treatment of common retina conditions is extremely helpful to maximize patient confidence in you as a provider.

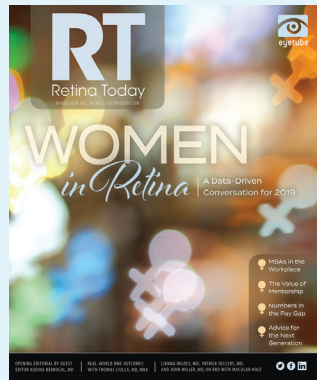
Dr. Kovacs: Did you ever feel that being the first female in a previously all-male group changed the practice-building landscape for you?

Dr. Bagheri: In my experience, people tend to like people that they are similar to or they identify with. Referring doctors and patients will end up gravitating toward certain providers over others. This is just one of the many reasons why physician diversity is so critical to maintain a healthy long-term practice.

Dr. Kovacs: What specific suggestions do you have for engaging with your referral base in the COVID-19 world?

More from Dr. Bagheri

Read Dr. Bagheri's thoughts about joining California Retina Consultants in "Starting Off as the First Female Physician in an All-Male Practice: Ten Tips," from our March 2019 issue at bit.ly/Bagheri1020.



Dr. Bagheri: I believe that a case-by-case approach is best in today's environment. Every referring provider will have slightly different expectations and preferences about social distancing,

in-person meetings versus virtual meetings, etc. As such, it is better to be conservative when unsure and to ask questions before presuming. Although a face-to-face meeting may not be possible, your voice in a direct conversation and your availability make a huge difference. COVID-19 has perhaps accelerated an already growing movement away from traditional strategies for building a referral base. Generally speaking, the younger generation of referring providers is comfortable with texting, calling, and virtual formats. ■

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