

Achieve Better Glaucoma Management: Become the Front Line of Care

Optometrists are uniquely situated to diagnose early and enact preventive care that will help preserve patients' vision.

BY ELLIOT M. KIRSTEIN, OD

In the vast majority of the United States, optometrists are responsible for patients' initial eye examinations. As primary eye care providers, we optometrists are uniquely situated to identify glaucoma suspects during routine and scheduled examinations—and if we do not, people will lose vision.

Within eye care, the medical practice of ophthalmology is divided into various subspecialties—cataract, refractive, retina, neuro-ophthalmology, and glaucoma. Our medical colleagues are highly trained to treat and manage end-stage disease, but they often do not have the facility or the mindset to diagnose conditions earlier. As optometrists, we are on the front lines of diagnosing the masses.

PROTOCOLS FOR TREATING PATIENTS

Two different scenarios occur when a patient presents to my practice. The first example is when my colleagues and I discover a patient is a glaucoma suspect during what otherwise would be a routine examination. The second is when another physician identifies a patient as a suspect and refers him or her to our practice for a second opinion or a glaucoma workup.

If a patient is coming in for a routine examination seeking a change in his or her spectacle prescription, we might find certain risk factors in the context of the examination that indicate a workup for glaucoma is indicated. The risk factors might include increased intraocular pressure (IOP) or a suspicious nerve or anterior chamber angle. A strong family history will also raise the index of suspicion. We explain to these patients that we have a reason to believe that he or she is a glaucoma suspect. We have the patient return for a glaucoma workup, which will include tests that will help us determine whether the patient has glaucoma and whether we think he or she needs treatment.

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If a glaucoma suspect is referred to our practice, the referring physician might have identified the IOP or suspicious nerve already. These patients are scheduled for a thorough glaucoma workup including optical coherence tomography (OCT; I use the iVue by Optovue in my practice), ultrasound biomicroscopy (UBM; I use the Aviso system by Quantel), digital optic nerve evaluation, threshold visual field analysis, gonioscopy, pachymetry, and IOP measurement. If we feel that the patient is at risk for glaucoma or already has glaucoma at a certain level, we might suggest treatment. Then, we schedule the patient to return so that we may test the efficacy of the treatment and to see how well he or she is doing.

We follow separate protocols for patients who are under treatment and patients who are being “followed.” A treated patient receives two threshold visual fields per year, an OCT scan, fundus imaging twice per year, IOP measurements four times a year, gonioscopy once or twice a year, and UBM once per year. Patients who are not being treated are followed and retested on an annual or semiannual basis, depending on the nature and severity of their risk.

CHALLENGES IN MANAGEMENT

One challenge of treating glaucoma is convincing patients to comply and adhere to the suggested protocol. Patients have to come back for repeat visits, take costly medication that might irritate their eyes, and they typically have no symptoms of the disease. Vision loss in glaucoma comes late in the disease, and our job is to prevent that vision loss while the patient is still asymptomatic.

A human element also plays a role in managing glaucoma patients. As clinicians, we continue to improve our skills and expand our knowledge, but at the end of the day, managing glaucoma comes down to our relationship with our patients. Thus, an important and significant variable in the success of treatment is our ability to convince patients to comply and adhere to our recommendations.

CONSIDERING SURGERY

Recent advances in glaucoma surgery, including the introduction of new techniques and technologies, have significantly improved both the safety and efficacy of surgical management. Still, glaucoma surgery does not even come close to achieving the kind of success and expectations associated with, for example, cataract surgery.

For patients with heart disease, diet, exercise, and medication are preferred rather than sending a patient off for coronary artery bypass surgery. Similarly, we want to catch glaucoma early and mitigate the disease process as early in its course as possible. Early diagnosis and effective intervention may help prevent the need for surgery.

CONCLUSION

The standard of care of glaucoma has changed, and we are expected to keep up with current treatments. It is important for us to invest in imaging modalities, such as OCT and UBM. These instruments are affordable, available, and, owing to years of innovation and development, accurate. Advanced imaging technology, coupled with a proactive attitude that emphasizes ongoing, preventive care and a strong doctor-patient relationship, reduces the need for surgical intervention and leads to sustainable ocular health. ■

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