Our annual SVOS Lake Tahoe Seminar was a tremendous success again this year! We had over 100 doctors attending from as far away as Hawaii and New Jersey. The MS Dixie dinner cruise was well attended and again sponsored by VSP. Thank you VSP! And for the first time we had an all age mini-golf tournament. Thank you to the Retinal Consultants group for sponsoring this first annual mini-golf event that was enjoyed by all.

We had even more vendors this year, including: Alcon, Cooper Vision, Mobile Glaucoma Solutions, Ciba, Ista Pharmaceuticals, Optovue, ABBConcise, Allergan, Carl Zeiss Meditec, Cioosoft, Zevision, Find Your Local Doctor.com, Primary Eyecare Network and Oasis Medical. A BIG thanks to all of our sponsors for contributing to the success of our seminar.

For the first time we had the dynamic duo of Dr. Carlo Pelino and Dr. Joseph Pizzimenti conduct several lectures side by side that made for a very entertaining and easy listening format.

I would also like to recognize and thank Linda Rappa for her tireless efforts to coordinate all the speakers and all the details that made this event possible. Also, thank you to Karen Darkenwald for helping with registration and keeping us on schedule.

Please mark your calendars for the COA House of Delegates on January 29-30 at the Ontario Airport Marriott Hotel. Attending the HOD is a great way to get to know your COA leaders and learn about the legislative issues that face our profession.

I look forward to seeing you on October 20th at our next general meeting at VSP headquarters.

Sincerely,

Donna Scolaro, OD, SVOS President

A Fabulous 2009 Tahoe Seminar

This July’s annual Tahoe Seminar continued the tradition of excellent education with a format that allows enjoyment of the beautiful surroundings. The featured speakers this year were Joseph Pizzimenti, O.D., FAAO, who is an associate professor at Nova Southeastern University College of Optometry and Carlo Pelini, O.D., FAAO who is an assistant professor at the Pennsylvania College of Optometry. They provided eight of the twelve education hours in a tag team fashion with the following topics: “The Eye in Obesity”, “Pharmacotherapy of Ocular Disease”, “Twelve Angry Eyes”, and “Conversations in the Glaucomas”. Local retinologists Dr. Joel Pearlman and Dr. Tony Tsai provided programs on “Advances in Retinal Imaging” and “Retinal Venous Occlusive Disease.” In addition, David Kading, O.D., FAAO with Seattle Eye Care Group provided contact lens insight with “Focusing Near without Fear” and “Update on Keratoconus.” Overall, the lectures provided a tremendous amount of useful clinical information.

On Friday evening doctors and spouses were treated to a scenic dinner cruise on the MS Dixie. Saturday afternoon featured a miniature golf tournament. Educational meetings were completed by 1:00 on Saturday and 11:00 on Sunday to enable enjoyment of all that Lake Tahoe has to offer. Exhibitors provided information about equipment, labs, contact lenses, pharmaceuticals and practice management. Their sponsorship keeps the cost relatively low. For over 20 years this seminar has been held on the last weekend in July…..mark your calendars for next year!
Q: In refractive surgery, when should ASA (PRK) be recommended? When should Lasik be recommended?
A: There are many factors to consider—primarily risk tolerance vs. pain tolerance as well as corneal thickness limitations. If the corneal thickness is less than 500 microns, almost never do Lasik (there are rare exceptions with small corrections). If the patient has an occupation with a high risk of eye injury (military, fireman, law enforcement), consider ASA. If the patient is elderly, has poor epithelium, dry eye or is post-cataract, think ASA. Remember it takes approximately 13 microns per diopter of treatment. Therefore, a 10D myope will lose approximately 130 microns of corneal tissue...that's a lot. If the residual K's will be less than 35D, don’t do it. (The ablated corneal shape will never provide optimal visual quality.) For example, an initial K reading of 42D treated for 7D of myopia will result in a 35D keratometry reading. It turns out that the fast recovery, minimal discomfort, happy “wow factor” and faster post-op chair time will make it appropriate to do Lasik approximately 80% of the time.

H. Douglas Cooper, MD graduated Brigham Young University and went on to train as an Ophthalmology Resident at Tulane University. He has a local private practice specializing in the treatment of cataracts and glaucoma. He is a medical director at Pacific Laser Eye Center (PLEC) where he specializes in refractive surgery.

October 20th
General Meeting at VSP

Please note that the October 20, 2009 general meeting will be held at VSP Headquarters at 3333 Quality Drive in Rancho Cordova. The meeting begins at 6:00 pm with drinks and socializing. A buffet dinner will be served at 6:45. Patricia Sierra, MD is the featured speaker, and her topic is “Surgical Options for the Treatment of Keratoconus & Keratectasia.” She is a surgical eye specialist with Grutzmacher and Lewis in Sacramento.

VSP will ask you to sign a guest waiver at the security entrance and you will need a visitor badge to be granted building access. Directions from downtown Sacramento: Hwy 50 East: exit @ Zinfandel South. Turn right on Zinfandel then right onto Data Drive then left on Quality Drive. Park in the main campus parking lot and enter the six story building.

Please RSVP to Jerry Sue at the SVOS office before October 15th. This meeting will have a large turnout so PLEASE do not show up without pre-registering. The catering will be buffet style—and vegetarian friendly.

The meeting is free to SVOS members. Non-members price is $45.

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CONGRATULATIONS!

Dr. Joe Huang and his wife Dr. Jennifer Fong welcomed their second daughter, Joelle Lynn, on August 14, 2009. Here she is being snuggled by big sister Jordyn Emily, age 20 months.

Our Tahoe seminar welcoming committee: Dr. Steve Omoto, Dr. Linda Rappa and Dr. Heidi Schauffele.

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Corneal Infiltrates in the Contact Lens Patient: Is it Infectious?

Our most feared complication when assessing corneal infiltrates in contact lens wearers is infectious corneal ulceration. Most frequently, corneal infiltrates are secondary to other conditions that must be distinguished from infected ulcers.

Contact lens solutions can be associated with delayed-type hypersensitivity and toxic reactions presenting with multiple peripheral subepithelial sterile corneal infiltrates. Similarly, corneal infiltrates can also be seen in the setting of corneal hypoxia or a tight lens syndrome. Patients with blepharitis may also present with perilimbal infiltrates related to staphylococcal hypersensitivity. These are usually parallel to the limbus but separated from it by a clear zone approximately 1 mm wide. Subepithelial infiltrates associated with adenovirus tend to have a diffuse rather than peripheral presentation and there is usually a history of recent conjunctivitis or “pink eye.”

When assessing contact lens patients with corneal infiltrates, it is important to obtain information regarding the type of contact lens, lens care and usage. Overnight wear of lenses continues to carry an eightfold increased risk for infectious corneal ulceration.1-4

A detailed history and careful examination can provide distinguishing features. Patients with infectious keratitis tend to have moderate to severe pain, dense infiltrates usually larger than 1 mm in diameter, anterior chamber reaction, a mucous discharge clinging to the lesion and an overlying epithelial defect. On the contrary, patients with sterile infiltrates usually have minimal pain, quiet anterior chamber and infiltrates that are usually smaller than 1 mm in diameter with overlying superficial punctate keratitis. When corneal edema surrounds the infiltrate or when there is an anterior chamber reaction, infection must be suspected.

Treatment is dictated by the suspected underlying cause, determined from the history and clinical examination. Topical steroids are best avoided as the initial treatment of infiltrates in contact lens wearers.

If a reaction to preservatives in lens solutions is suspected, discontinuing lens wear until symptoms and signs resolve, replacing the contact lenses, switching contact lens solutions or recommending a peroxide disinfection system should alleviate the problem. Daily disposable lenses are a good option in these cases.

Infectious corneal infiltrates associated with contact lens wear must be recognized and proper care instituted immediately. Frequent organisms isolated in contact lens wearers are *Pseudomonas aeruginosa*, *Staphylococcus aureus*, or *Staphylococcus epidermidis*.5 Standard care for suspected microbial keratitis is intensive broad-spectrum antibiotic therapy. Small infections can be treated with commercially available fluoroquinolones every hour after a loading dose every 30 minutes for 5-6 doses. Cultures should be obtained if the infiltrate is larger than 1-2 mm, if the keratitis is getting worse on treatment, or if an unusual organism (fungus, *Acanthamoeba* or atypical mycobacterium) is suspected on the basis of the history or clinical appearance. For more serious infections, larger size ulcers or those involving the visual axis, broad-spectrum topical fortified antibiotics (fortified cefazolin and tobramycin or fortified amikacin and vancomycin) should be used.

**Case Examples**

**Case 1**

A disposable extended-wear lens user presented with complaints of severe pain and photophobia. Examination revealed two peripheral infiltrates measuring 0.5 and 0.2 mm in diameter. There was associated surrounding corneal edema and moderate anterior chamber reaction. Infection was suspected. Cultures were taken and patient started on high concentration topical levofloxacin (Iquix) every hour around the clock. Cultures were positive for heavy growth of *Pseudomonas*. Patient responded well to treatment.

**Comment:** Small infiltrates may be infected. Associated pain, corneal and anterior chamber inflammation strongly suggests infection.
References:

Case 2
A young female, extended-wear lens user presented with complaints of eye redness and mild discomfort. Examination revealed two peripheral infiltrates. Cultures were done and treatment initiated with intensive topical moxifloxacin (Vigamox). Responded well. Cultures were negative.
Comment: In the absence of significant pain, anterior chamber reaction or surrounding corneal edema, these infiltrates are likely to be sterile.

Dr. Joseph J Pizzimenti, FAAO and Dr. Carlo J Pelino, FAAO were both at our recent Tahoe seminar.

**Question:** How can optometrists be more pro-active in the war against AMD?

**Answer:** In addition to close monitoring of our AMD patients, the optometrist can be an important resource for patients seeking to achieve optimum macular health and protection. We can start by advising patients to eat a balanced diet that is high in fish, and whole grains, emphasizing fruits, vegetables (especially greens), and fat-free or low-fat dairy products. The diet should also include lean meats, poultry, beans, eggs, and nuts. It should be low in saturated fats, trans fats, cholesterol, salt (sodium), and added sugars.

A broad-spectrum multivitamin may be advisable for patients who are unable to achieve these dietary goals. For patients with early signs, or those at risk for AMD due to genetic, personal, systemic, or environmental factors, it may be prudent to also supplement with both zeaxanthin and lutein. For zeaxanthin, a dosage of approximately 4-mg to 10-mg per day, depending upon the patient’s diet (especially green vegetable intake), body mass, and other health factors, is generally appropriate. For lutein, a dosage of approximately 6-mg to 20-mg per day is generally appropriate, again depending upon the various patient characteristics.

If a patient meets the AREDS 1 criteria (intermediate AMD or advanced AMD in one eye but not the other), it is appropriate to supplement with the AREDS 1 formulation. If you have questions about a vitamin supplement’s appropriateness for a particular patient, it would be prudent to first contact the patient’s primary physician, pharmacist, or a nutritionist before proceeding.