WHAT’S YOUR GAME PLAN?

For patients with common ocular pathologies, it pays to have a plan in place.

BY MARGIE RECALDE, OD, FAAO

The Scout motto, “Be Prepared,” is good advice—even for those outside of Scout life. For optometrists, it is important to have a treatment and management plan in place for some of the pathologies we see commonly in practice. Having a methodical and organized approach to examinations and treatment plans helps to prevent the waste of time and effort on unnecessary steps and actions and to ensure that we are less likely to make mistakes and jump to wrong conclusions.

This article details my general strategies for treating and managing patients with diabetes, age-related macular degeneration (AMD), glaucoma, and cataract.

COLLABORATING CARE FOR PATIENTS WITH DIABETES

Patients with diabetic retinopathy should be referred to a retina specialist. To retain your relationships with these patients, be sure to refer them to a retina specialist who is willing to team up with you and keep you informed about your patients’ conditions.

If I have images that show bleeding in the back of the patient’s eye, I share them with the patient to drive home the importance of following through with scheduling an appointment with the retina specialist. I make sure to explain that blood sugar, blood pressure, cholesterol, diet, and exercise habits all play a role in the patient’s prognosis. I also inform the patient that he or she will still need to be seen in my office for annual comprehensive examinations to make sure he or she is seeing as well as possible and to monitor overall eye health. The retina specialist, I explain, is focusing only on the diabetic retinopathy.

Once you have referred a patient for care, treatment decision-making is up to the retina doctor. While the patient is under the care of the retinal physician, I update the patient’s primary care physician about the patient’s condition and the referral for specialty care.

Follow-up care depends on the patient’s condition. If a patient’s test results are normal but I am concerned that macular edema might develop, I may ask that patient to return to my office within 1 or 2 months, especially if his or her diabetes is not well-controlled. If the patient’s diabetes is relatively well-controlled, then I may suggest returning twice a year or more frequently, depending on the severity of the condition.

If the patient requires treatment with laser photocoagulation or anti-VEGF injections, then the retina specialist will manage the patient until the condition is stabilized. In most situations, the retina specialist
will refer the patient back to me for annual comprehensive examinations.

**KNOW WHEN TO MANAGE AND WHEN TO REFER AMD**

If I suspect that a patient has AMD, I use an OCT of the macula to explain what I am seeing. I then review the risk factors for AMD with the patient, dividing them into those that cannot be changed (eg, age) and those that can be modified (eg, smoking and diet).

Because there is no treatment for dry AMD, I speak to patients with this form of the disease—as well as patients at risk of developing AMD because of a family history—about vitamins they can take to improve macular pigment and slow progression of the disease. I also show them how to use an Amsler grid test to monitor their condition themselves.

For patients diagnosed with AMD, the retina specialist is typically the eye care practitioner who handles all treatment decision-making and planning. Patients with wet AMD are referred right away. In most cases, the patient is sent back to me for annual comprehensive eye examinations.

**CARING FOR PATIENTS WITH GLAUCOMA**

If you employ a methodical approach to using the standard tests (eg, tonometry, ophthalmoscopy, perimetry, gonioscopy, and pachymetry) for patients with glaucoma, you will be able to differentiate between open-angle, angle-closure, narrow-angle, and mixed-mechanism glaucoma. Patients with normal-tension glaucoma are trickier to diagnose and treat because you can’t rely on their IOP as an indicator of disease.

As a glaucoma-certified optometrist, I can initiate medical treatment for my patients who have the disease. I typically prescribe medications that require administration only once a day to try to make adherence to the treatment regimen as easy as possible.

When I speak with patients about their diagnosis and the treatment I recommend, I want them first to understand that the medication must be used from now on. I tell them that they will not notice their eyes feeling or seeing better because this is not what the drops are meant to do. I explain that the medication is meant to lower the pressure in the eye and that they won’t be able to tell if it is working, which is why they need to come to the office to be checked regularly. I review the possible side effects of whatever medication is prescribed, and I let them know that they can call our office any time with concerns.

I typically monitor patients with glaucoma more frequently (about four times per year) during the first 1 or 2 years after diagnosis to ensure that they are stable before letting them go for longer periods of time (two to three visits per year) between follow-up visits. I refer to a glaucoma specialist if I find that a patient’s glaucoma is not being controlled with medication, that the side effects of the medication are not tolerable, that the patient is not able to switch to another medication due to dosing concerns, or that the patient has an advanced condition that I feel is best handled by specialty care.

When we comanage with a glaucoma specialist—or any other physician for that matter—communication is of the utmost importance. I fax over the results of all the patient’s tests so that the glaucoma physician is up to speed and not starting from scratch. Keeping them informed is a good way to ensure that referring physicians return the favor.

**MANAGING PATIENTS WITH CATARACTS**

When I diagnose patients with cataracts, I explain what a cataract is and how it is affecting their daily life. I also inform them that the condition is treatable and, assuming my examination findings indicate that they are good candidates for cataract surgery, I let them know that I am going to refer them to a cataract surgeon. Before a patient sees the cataract surgeon, I go over the treatment options available, including a standard implant that may require use of glasses to see up close or a premium implant that would cost extra but provide good vision up close without glasses.

The cataract surgeon typically sends patients back to my office the day after surgery. During this visit I make sure patients are using their medications properly. I provide a summary of the visit to the cataract surgeon and have the patient return to my office 2 weeks later, then again at 1 month to ensure that he or she is adherent with the postoperative medications. At about 1 month postoperatively I perform manifest refraction to determine whether the patient needs glasses and also whether he or she is stable enough to discontinue the postoperative medications. At this time I also conduct a comprehensive eye examination and, for patients who do not achieve 20/20 BCVA, OCT imaging to check for macular edema. I share all information gathered with the patient’s cataract surgeon.

**STANDARDIZE FOR SUCCESS**

I hope this brief description of how I approach the treatment and management of patients with common ocular diseases provides you with a few pearls you can implement in your own practice.

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