

President's Insights January 2023

Technology: A Love / Hate Relationship

Part One: The Love

Like many of our colleagues, I am a bit of a gadget nerd and have strived to incorporate new technology into our practice whenever possible. We purchased an OCT for the practice about seven years ago and now I don't know how we ever practiced without it. There is an array of new technologies that I believe will change how we provide eye care for the better, especially to those in need or in underserved communities. At the same time, I am also concerned with the potential for abuse and substandard care that is already oozing into the eye care profession.

I will start on the pro side of technology with a heartwarming story. Right after Thanksgiving, an apparently healthy 28-year-old new patient came in for an exam. His chief complaint: he wanted to replace the sunglasses that he lost when he left them in a rental car while on vacation. He had no ophthalmic complaints, nor did he have vision complaints. I started the exam by doing the history and then turned the exam over to my extern. When Emily presented to me, she said that all entrance tests were normal (note: even confrontation fields), there was virtually no change in the glasses prescription, and the anterior segment was healthy. The one significant positive was that the borders of both optic nerves were blurred. I mentally shrugged a little. The externs can get overly excited with a new finding, and I expected to find nothing more ominous than optic nerve drusen. I picked up my 78D lens, looked, and agreed that the borders were indeed significantly blurry.

I calmly asked Emily to run an OCT cube and a five-line raster of the optic nerve. The CDs were 0.05 and the cup volume 0.000 in both eyes. The neuro-retinal rim thickness and the retinal nerve fiber thickness were both off the charts. The five-line showed the vertical pyramid shape and anterior displacement of the Brucks / RPE complex consistent with papilledema. Of course, the entire time, we were both commenting that this is not the pathognomonic presentation of papilledema. Luckily, he was the last patient before lunch, so we had time to also run a visual field without throwing off the rest of the day's schedule. My heart sank a bit when the results showed a homonymous inferior-left quadrantanopia with enlargement of the right blind spot. Note: the visual field defect was not dense enough to pick up with the confrontation fields.

After collecting myself for a moment, I returned to the exam room and told the patient that I knew he was expecting to leave the room and go to the optical to choose sunglasses, but that I had just spoken to the attending at the emergency department at the local hospital and that they were waiting for him. As his partner came to get him, we quickly sent all of the examination findings including photos, OCT, and fields to the hospital. He was then transferred to a larger nearby hospital where he had a 6 cm meningioma removed two days later.

During the holidays, he brought his parents into the office so we could meet. We had a lovely, touching chat. He mentioned that he was doing really well and that occupational and visual therapy was helping him work on saccades and the visual confusion that groups of objects were causing him. Just after the new year, I received one of the best gifts ever – a photo of the extended family holding a sign that said, "We love Dr. Cizek". There may have been a few tears shed that day.

It is marvelous that an optometrist in a primary care setting had the technology to provide a detailed, comprehensive evaluation and referral directly to the hospital without requiring an intermediate consultation.

Part Two: The Hate

One of our patient care coordinators was the only employee who, due to a combination of circumstances, did not return to work when we reopened after the covid closure in 2022. Having parted on good terms, we kept in touch and were aware that she had been working in another optometric office in the area. When we spoke in November, she mentioned that she was working in a real estate office. When asked why she left, she replied that she did not feel comfortable working for the other company because they trained her enough to “fake” her way through an eye examination, and then later, a doctor would remote into the exam room to answer any questions the patient might have.

Coincidentally, this situation was confirmed later in the afternoon on the same day as the patient with the meningioma I refer to in Part One. A husband and wife, both new patients, came in both complaining of a horrible experience at their last exam, and independently described the situation almost exactly as our ex-colleague had. A short visit with a technician and then after an hour and a half wait, a virtual consultation with the doctor. The husband asked several times why he had such a considerable increase in the astigmatism in his left eye and never received a satisfactory answer.

We did the wife’s exam first. It was completely unremarkable, and we ended up prescribing the exact same lenses she had been wearing. The husband was complaining of blurred vision and significant glare in his left eye. He admitted that he overwore his two-week lenses for up to 2 months at a time. He recalled an episode roughly two years prior when he scratched his eye removing his left lens which resulted in blurred vision for over a week.

The best-corrected vision in the right eye was a weak 20/20 and a weak 20/25 in the left. Corneal topography showed a significantly high corneal asymmetry index in both eyes. There was about 1.5 mm of corneal neovascularization and moderate diffuse staining with NaFl in both eyes, and mild anterior stromal haze in the left eye. I explained to him that because of the combination of the injury to his left eye and the contact lens overwear, he needed significant corneal rehabilitation and that he was at risk for future recurrent corneal erosions. I saw him for a progress report this week. Both eyes showed significant improvement. The right cornea had a normal corneal asymmetry index. The left cornea is healing in the classic pattern of centripetal migration and still has a high corneal asymmetry index. I expect that the left cornea will continue to heal and normalize within the next week or two, however, the risk of recurrent erosion remains.

As I was not present at his examination a year ago, I have to take the patient’s account for granted. He does have the prescription for an exam a few years ago with virtually no astigmatism in both eyes and the exam from a year ago showing 2D of astigmatism in the left eye only. The fact that he feels that he did not receive satisfactory care gives me pause. The possibility that a condition was overlooked by a doctor, at best, virtually reviewing a patient’s case gives me concern. The thought that my meningioma patient could have chosen to go to a doctor who only provided a virtual evaluation alarms me.

These two experiences made me think a lot. I am all for incorporating technology into our examinations and patient care, as long as the technology benefits the patient, and it is not just used as a shortcut in place of a proper and professional examination. I am encouraged by the increasing availability of technology that may help us care for patients in remote areas or those without access to care. Technology use is linked to the accountability we have to our

patients and should always be framed by strong ethical considerations. While I hope that all VOSHers will adopt any and all technology that furthers our goal of eliminating blindness, I also encourage you to use it as a tool to deliver the most thorough examination your country allows you to do and always based on the ethical, compassionate, and comprehensive care our patients deserve.

Sincerely and Best Regards,

Michael Ciszek, OD, FVI,
VOSH/International President