

Georgia Retina, P.C.

Fall 1999

The Light Pipe

Practice News

The practice of medicine has changed dramatically in the second half of the twentieth century, and the rate of change seems to be accelerating rapidly. At Georgia Retina, we have been presented with several wonderful opportunities in the midst of all these changes.

First, we would like to welcome to our physician staff, Dr. Charles Harris, who joined us in July. He and his wife are both originally from Savannah. Dr. Harris has impressive credentials, and has just completed an excellent two year fellowship in which he had very broad exposure to the whole spectrum of retinal and vitreous disease, along with the opportunity to personally perform a large number of complex surgical procedures. We look forward to a long and happy association with Dr. Harris.

On the south side of town, our Riverdale office has moved, to new quarters at 155 Medical Way, just a couple of blocks away from our old, somewhat cramped space. The new office is much more spacious, completely renovated, and will certainly allow easier access and more efficient patient flow. Of course, the new office is fully equipped for photography, angiography, ultrasonography, and laser treatment. Our staff and patients are very happy with the move to these much more comfortable surroundings.

On the north side of town, several changes have occurred. As many of you know, Dr. Bruce Becker retired from the practice of medicine this spring, and has become an attorney. He has asked us to take over the care of his patients, and we look forward to continuing the tradition of high quality care to which his patients are

accustomed.

Additionally, Dr. Frank Bell retired from the practice of medicine at the end of July, and we will be continuing his practice, in two separate ways. First, we look forward to continuing the excellent level of care which he has afforded his patients in the past. We also will be utilizing Dr. Bell's office at 5671 Peachtree Dunwoody Road, in the St. Joseph's Hospital complex. That office is fully equipped with photography, angiography, ultrasonography, and laser. Over the past several years, many of our existing patients have asked us for an office on "Pill Hill", and we look forward to accommodating our patients in whichever office they choose.

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Update on Research at Georgia Retina

Currently we are involved in several studies at Georgia Retina. The first, is a study of **limited foveal translocation for subfoveal neovascularization associated with age related macular degeneration**. This is being done under an investigational protocol approved by the Institutional Review Board at DeKalb Medical Center. When faced with choroidal neovascularization directly under the fovea we have had no treatment that can offer the patient any hope of visual improvement. Until recently we could only offer the patient direct laser ablation of the fovea in an attempt to contain the further expansion of the membrane and enlargement of their central scotoma. This treatment was shown to be of benefit in preserving, but not improving vision, in the Macular Photocoagulation Study. It is difficult for both patients and doctors to accept.

Recently, Eugene DeJuan, at Johns Hopkins University described a procedure whereby the fovea can be moved to a new location, away from the CNV, to allow laser treatment of the membrane, without destruction of the fovea. The procedure entails performing a pars plana vitrectomy, and creating a retinal detachment by injecting balanced salt

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Intraocular Foreign Bodies

Managing intraocular foreign bodies (IOFBs) is especially challenging both in diagnosis and treatment. The patient's history is the key to suspecting an IOFB. Hammering metal has historically been the leading cause, although working with machine tools such as grinders, chopping wood, and BB guns are other sources (1,2).

Ferromagnetic (metallic) IOFB's are the most common type. Careful fundus examination can discover foreign bodies if the media is clear, although corneal lacerations, traumatic cataract and vitreous hemorrhage can make this determination difficult. Minimal manipulation of the eye is important. If the globe is perforated an eye shield should be placed immediately and intraocular pressure measurement might be deferred for this reason. Ancillary tests to detect and localize the IOFB include plain X-ray, computed tomography (CT scan) and B-scan ultrasonography.

B-scan should probably be deferred in the presence of an open globe unless the laceration is very small and the globe is maintaining good pressure. Magnetic resonance imaging (MRI) is, of course, contraindicated if metallic IOFBs are suspected.

The IOFB should be removed acutely if infection is present or if the IOFB is composed of material which is toxic to the eye (e.g. iron or copper). The need for removal of chronic and encapsulated IOFBs are more controversial unless siderosis bulbi or infection develops. Treatment of these injuries has made significant advances. The rate of retinal detachment following removal has declined from approximately 30% in the 1930's to below 10% in the 1980's (3). The posterior vitrectomy combined with pars plana removal of IOFB's offer minimal damage to the ocular structures. Simultaneous removal of intravitreal blood eliminates this risk factor for proliferative tractional

retinal detachments.

Rare earth magnets allow very controlled manipulation and removal of metallic foreign bodies through the pars plana. This is superior to the older external magnets that result in a more unpredictable path between the impact site and the magnet. Non-magnetic removal is best performed with intraocular forceps that will grasp objects of irregular size and shape.

Endophthalmitis is a concern, and prophylactic treatment with intraocular antibiotics at the time of surgery may be prudent.

A patient was injured while working in a die metal shop without safety glasses, seven days prior to exam. Two days earlier a primary corneal wound closure was done. He presented with 20/40 corrected visual acuity, with a small peripheral traumatic cataract posterior to the sutured corneal wound (figure 1) and

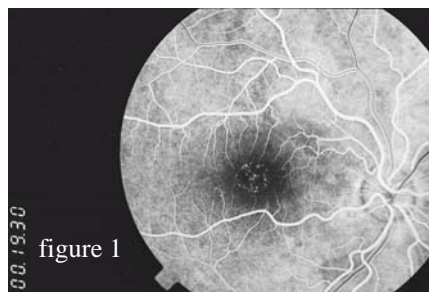


figure 1

a metal fragment resting on the posterior cortical vitreous (figure 2). A trans pars plana vitrectomy and the fragment removed through an enlarged sclerotomy using both intraocular forceps and magnet. This controlled removal avoided any retinal injury and no further contact with the lens with retention of his baseline acuity.

References

- Behrens-Baumann, W., Praetorius, G.: Intraocular foreign bodies. *Ophthalmology* 198:84-88, 1989
1. Coleman D.J. et al.: Management of intraocular foreign bodies. *Ophthalmology* 94: 1647-1653, 1987.

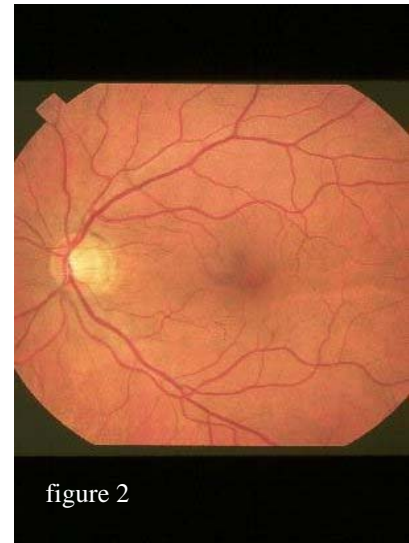


figure 2

2. Cooling, R.J. et al.: Closed microsurgery in the management of intraocular foreign bodies. *Trans. Ophthalmol. Soc. U.K.* 101: 181-183, 1981.
3. Cooling, R.J. et al.: Closed microsurgery in the management of intraocular foreign bodies. *Trans. Ophthalmol. Soc. U.K.* 101:181-183, 1981.

Charles L. Harris, M.D.

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With new patients added to our practices, new offices, and a new physician, we have also begun to utilize other operating rooms. In addition to Metropolitan Hospital and Decatur Hospital, where we have performed most of our in-hospital surgery, we are increasing our flexibility by utilizing the operating rooms at Northside Hospital and St. Joseph's Hospital.

With all these changes, Georgia Retina is still committed to providing the highest quality one-on-one personalized care to each patient. Stay tuned to this channel for the latest news.

Scott I. Lampert, M.D.

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solution into the subretinal space. The sclera is then imbricated with sutures. When the retina is reattached after an air/fluid exchange, the position of the retina with respect to the RPE is shifted. The sclera is imbricated in

patients any hope of visual improvement.

Another study, which is in its incipient stages, is of **Retinal Vein Sheathotomy (surgical decompression) for branch retinal**

“This is the only procedure available which offers these patients any hope of visual improvement.”

the superotemporal quadrant, so the retina is shifted inferiorly. The maximum displacement attainable was initially described as being about one disc diameter, although we have observed greater movement. Once the fovea is displaced away from the CNV, fluorescein angiography is repeated, and foveal sparing laser ablation of the membrane is performed. Patients may have cyclotorsional diplopia, as a result of rotation of the retina. Interestingly, this usually resolves spontaneously within about six months, as a result of cortical re-orientation of the image. The surgery can be done under local anesthesia, on an outpatient basis, but requires 1 ½ to 2 hours to complete.

Patients are well informed of the risks of the procedure, which include recurrent retinal detachment, vitreous hemorrhage, PVR, cataract, and either excessive, or inadequate movement of the retina. We have performed the procedure on 12 patients to date, and several have had remarkable improvement in vision. The postoperative course can be extremely complex, and may require repeat air/fluid exchange, and re-operation for the complications noted above. Of course, even after successful translocation and laser treatment, the membrane can reoccur. We are enrolling patients who have classic or occult subfoveal CNV of recent onset, (less than 3 months), the infer-most extent of which does not extend more than 1500 microns from the fovea. The margins must be well defined enough to estimate within 100 microns. This is the only procedure available which offers these

vein occlusion. This is an exciting new procedure where we incise the common adventitial sheath around a retinal artery and vein, at their crossing point. By dissecting out and elevating the vein (which runs anterior to the artery), the obstruction can be relieved. Opemcek and Bruce have reported preliminary results of this method in 15 patients, which has produced immediate re-perfusion of the retina in the affected distribution. All patients showed clinical improvement, and 10 of 15 had visual improvement. These patients averaged four lines of visual improvement. Only two patients had intraoperative bleeding, and these were not severe. We have performed this procedure on animal eyes in a laboratory, and are looking forward to investigating this promising new method.

We are also gaining experience with the the use of **non-vitreotomizing membrane peeling for macular pucker** (epiretinal membrane). In this surgery, epiretinal membrane peeling is performed without having performed a vitrectomy, and without putting fluid infusion into the vitreous. It is thought that the fluid infusion may play a role in the well known progression of nuclear sclerosis that occurs after vitrectomy, even without an air/fluid exchange. Vitrectomy may actually increase the likelihood of traction on the vitreous base, and iatrogenic retinal tears. Yasua Tano and co-workers from Japan recently published a series of 21 cases treated by this method. So far, both the

published results and our results are very encouraging. The surgical duration is shortened and rate of cataract progression seems diminished.

Finally, we have been working with sutureless techniques for vitrectomy surgery. Just as this has improved patient comfort and shortened surgical duration in cataract surgery, we hope to reduce patient discomfort, formation of suture granulomas, induced astigmatism, late suture erosion and other suture related complications which can occur with vitrectomy.

We are pleased to be able to offer these new therapies to eligible patients and to involve our referring physicians in their follow up.

Jay B. Stallman, M.D.



Georgia Retina
welcomes
Charles L. Harris, M.D.

Our Physicians

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Charles L. Harris, M.D.

We participate in the following insurance plans...

Aetna US Healthcare
Aetna Select Choice
Aetna Managed Choice
Aetna Open Choice
Aetna US Healthcare Medicare
AHI Georgia Healthcare Systems
American Medical Plans
Beech Street (PPO,WC)
Blue Cross Blue Shield
Blue Choice PPO
Blue Choice Healthcare Plan
Blue Choice Platinum (red silo)
Capp Care
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Cigna (PPO) (HMO) and for Seniors
Community Care Network, Inc.
Georgia Better Healthcare
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