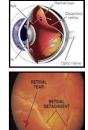




"Pathologic" Myopia

- Affects between 1-12% of patients¹⁻³
- Increased risk for:
 - Myopic maculopathy
 - Retinal detachment
 - Glaucoma
 - Cataract



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short-sightedness Early Interventions Slow Myopic Progression SCHOOL OF MEDICINE

Myopia Treatment Center

- Cost
- 1,000\$ to 3,000\$ per year
- Not Covered by insurance



What Does NOT Work?

- · Undercorrection:
 - Increases or has no effect on myopia progression¹⁻⁶.
 - It should no longer be advocated.
- Pin hole glasses: No Effect.
- Blue light blocking glasses: No Effect.
- Bifocal glasses:
 - Randomized, clinical trials in the US, Finland, and Denmark showed no significant slowing of myopia with bifocals alone⁷⁻¹⁰.





What Does NOT Work?

- Progressive addition spectacles:
 - Small benefit statistically significant but not clinically meaningful¹
- Peripheral plus/defocus correcting spectacles:
 - Aspheric spectacle lens did not lead to a decrease in myopia progression or axial elongation²⁻⁴
 - Positively aspherized PALs do appear to work⁵
- · Day time single vision soft contact lenses/rigid gas permeable contact lenses:
 - There was little or no effect⁶⁻¹³



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What Appears to Work: Behavioral Interventions

- · Increased time spent outdoors:
 - Effective in preventing onset of myopia 1-4
 - Mixed conclusion of slowing progression^{3,4}
 - 2 hours a day
- Reduced time on Smartphones/Near Digital Devices/Near Tasks: - The odds of myopia increased by 2% for every one
 - diopter-hour of near work per week5.
 - A working distance of <20 cm⁶.
 - Smartphone use⁵.
 - Near task in dim light⁵
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What Appears to Work: Glasses (not yet FDA approved)

- Defocus-Incorporated Multisegment (D.I.M.S.) Spectacle lenses:
 - This dual-focus spectacle lens central distance optical zone, surrounded by an annular mid peripheral zone that includes multiple (396) small round segments with a +3.50¹
- 50% Effect. Mid-peripheral blurred vision²
- Highly Aspherical Lenslet (H.A.L.) Spectacle



What Appears to Work: Contact Lens • Soft Multifocal Contact Lenses: - Center - distance with concentric rings as distinct zones of relative plus power Lenses with a gradient design and increasing plus power toward the lens periphery. 37% effect^{1.4}. Accumulation Effect⁵. Myopia control soft contact lens designs SCHOOL OF MEDICINE

What Appears to Work: **Contact Lens**

- Orthokeratology:
 - Overnight, reverse geometry hard lens.
 - Correction of myopia (up to −6 D sphere and -1.75 astigmatism)
 - Effect 50%. High drop-out rate in some studies. 1-21 Relative decrease efficacy over time^{5.} Rebound can occur.
 - Microbial keratitis (1.2 v 13/10,000) pigmented ring formation and altered corneal nerves²⁷⁻²⁸.





5

What Appears to Work: Atropine Eye Drops • Exact mechanism is unknown

- 1% atropine 77% effective1-5
- Atropine 0.5% (75%), 0.1% (70%), 0.01% (60%).
 Rebound greatest with higher doses. 5 year = 0.01% lowest progression = 50% effective
- Atropine 0.01% (27%), 0.025% (43%), and 0.05% (67%)6
- 10% may still respond poorly, even at higher





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Atropine Meta-analysis

 Optimal choice of management of myopia depends on treatment availability, acceptability to child and parents, and specific patient features such as age, baseline myopia, and lifestyle.

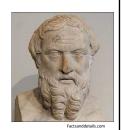


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Amblyopia SCHOOL OF MEDICINE

Definition of Amblyopia

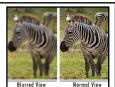
- "Amblyopia" = Dullness of vision1
 - Greek: 'ambly' dull
 - Greek: 'ops'- vision
- 480 BC Amblyopia²



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Neurologic Condition

- Decreased vision in one or both eyes
 - Disruption in the visual experience of a child in the first decade of life
 - Affecting their brain development
- NOT REFRACTIVE





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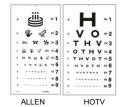
Causes of Amblyopia

- Refractive error $\sim 70\%^1$
 - Hyperopia / Astigmatism / Myopia
- Strabismus
- Esotropia, Exotropia
- Trauma
- Exotic
 - RB/ ROP/ Cataracts / Glaucoma



Amblyopia Diagnosis

- Best glasses Rx are used
- High contrast letter/picture optotype
 - Allen/HOTV/LEA
 - Snellen
- · Young kids?
 - Forced preferential looking/ object to occlusion



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How to Treat Amblyopia

- 1. Glasses
- 2. Occlusion (1742 Occlusion therapy¹)
- 1. Patching
- 2. Bangerter foil
- 3. Atropine 1%
- 4. Dichoptic/binocular
- 5. Acupuncture



| | Refractive Errors (dionters) | | | |
|---|------------------------------|----------------------|----------------------|----------------------|
| Condition | Age <1 year | Age 1 to <2 years | Age 2 to <3 years | Age 3 to <4 years |
| ometropia milar refractive error in both eyes) | | | | |
| Myopia | 5.00 or more | 4.00 or more | 3.00 or more | 2.50 or more |
| Hyperopia (no manifest deviation) | 6.00 or more | 5.00 or more | 4.50 or more | 3.50 or more |
| Hyperopia with esotropia | 2.00 or more | 2.00 or more | 1.50 or more | 1.50 or more |
| Astigmatism | 3.00 or more | 2.50 or more | 2.00 or more | 1.50 or more |
| nisometropia (without strabismus)* | | | | _ |
| Myopia | 4.00 or more | 3.00 or more | 3.00 or more | 2.50 or more |
| Hyperopia | 2.50 or more | 2.00 or more | 1.50 or more | 1.50 or more |
| Astigmatism | 2.50 or more | 2.00 or more | 2.00 or more | 1.50 or more |

Glasses: Common Sense Guidelines

IMHO: kids need an "ah-ha" moment to wear glasses

Ideally, they should help

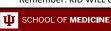




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Occlusion Therapy

- Patching
 - Part time patching
 - Mild amblyopia: 2-4 hours a day
 - Severe amblyopia: 6-8 hours a day
 - Full-time patching (1 week/year of age)
- Bangerter foil
 - Different filters for different severity
- Remember: KID WILL CHEAT!!







Atropine 1%

- Equal Efficacy to Patching in National Studies
- 2-7 days a week
- Atropine 2 days a week is roughly equivalent to patching 2 hours a day
- Aggressive: Plano/Atropine



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New Kid on the Block - Dichoptic therapy

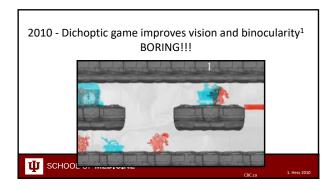


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Dichoptic therapy

- · Simultaneous and separate stimulation of both eyes
- Contrast for the good eye is reduced
- Video game tasks can only be solved binocularly
- Movies can be completely viewed binocularly





Movies! Movies! Movies!

- 2015 2020 Positive results both in-lab and athome
 - In lab: 1-2 lines of improvement in 2 weeks^{1,2}
 - At home: 1-2 lines of improvement in 12 weeks $^{\!3,4}$
- Limitations:
 - Size, weight make head-mounted display awkward
 - Visual isolation
 - Hard to check compliance
- No access to the public!



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Dichoptic therapy – FDA Approval 2023

- Equivalent to Patching!
- Expense?





Unanswered Questions?

- Device without glasses?
- Sub-population of kids this is more/less effective?
- Does more time = faster improvement?
- More months = more improvement?
- Cons? (3 movies/week)
- Is there regression after stopping the movies?
- Do we change to treating strabismus before amblyopia?



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Outcomes **Review of Clinical Trials**

- 1,760,066 Amblyopic patients identified¹
- Prevalence 2.5%. Clinical Success 83%
- Mean amblyopic eye visual acuity improved
 - 1.8 lines for kid 3-6 years of age
 - 0.8 lines for kids 7-12 years
- Residual amblyopia >2 lines
- · Reducing hours of patching/frequency of atropine
- There is no appreciable age effect if treatment is started before 5 years of age



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Outcomes Iris Registry

- New patients 3 to 12 years of age. 2013-
- "Treatment success" at 3-12 months:
 - Corrected interocular visual acuity difference of less than 2 lines
 - Improvement in the visual acuity of 3 + lines
 - Final visual acuity in the amblyopic eye of 20/30 or better



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12

Treatment Success: Gender and Race Age 3-7



- 18,841 kids 77.3% successful treatment
 - -Girls: Boys OR for success was 1.01 (95% CI, 0.94 1.08)
 - -Black: White OR for success was 0.71 (95% CI, 0.62- 0.83; P = 0.01)
 - Hispanic/Latino: White OR was 0.93 (95% CI, 0.83-1.04)
 - -Asian: White OR was 0.97 (95% CI, 0.77-1.23)



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Treatment Success: Gender and Race Age 8-12



- 9,762 kids 55.5% successful treatment
 - -Girls: Boys OR for success was 1.05 (95% CI, 0.97 1.14)
 - -Black: White- OR for success was 0.81 (95% CI, 0.68 0- 0.96;
 - -Hispanic/Latino OR was 1.16 (95% CI, 1.03 1.31; P = 0.01)
 - Asian children OR was 1.28 (95% CI, 0.97 1.67)



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Treatment Success: Insurance



Age 8-12



- Medicaid: OR was 0.65
- (95% CI, 0.60 0.71; P < 0.01)
- Medicare was 0.74 - (95% CI, 0.53 - 1.02)
- Military coverage was 0.91 - (95% CI, 0.68 - 1.23)
- Medicaid was 0.84
 - (95% CI, 0.77 0.93; P < 0.01)
- Medicare was 0.80 - (95% CI, 0.56 - 1.14)
- Military coverage was 1.02 - (95% CI, 0.75 - 1.40)

Why are Outcomes so Important?

- · Reduced vision one or both eyes
- Slowed binocular reading speed
- Decreased motion detection
- Reduced self-perception
 - Peer acceptance
 - Physical competence
 - Persist AFTER "corrected"







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Screening Efforts Have Decreased

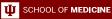
- Vision Screening steadily declined from 2016 -2020 (70% to $60\% P < 0.001)^3$
- Of those screened, there was a decrease in % screened by a specialist (56% to 50%. P < 0.001)¹



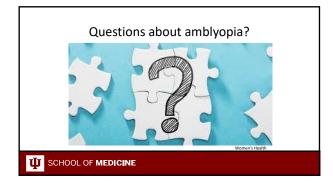


Discrepancy in Health Care = Problem!

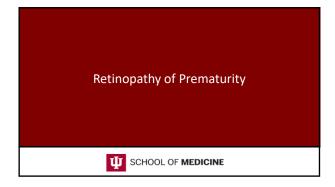
- · Poorer outcomes for Black children and those with Medicaid
- Need to develop and test strategies to improve treatment outcomes
 - Socioeconomic factors
 - Cultural factors
 - Access to eyeglasses/eyeglasses replacements/Treatment
 - Unconscious physician bias



| - | |
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| | |
| | |







ROP - ICROP 3

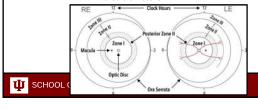
- International Classification of ROP (1984, 2005, 2021)
- Reasons:
 - Subjective elements of classification
 - Innovations in imaging
 - Novel pharmacologic therapies
 - Recognition of pattern in other regions of the world



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Subjective Classification

- Posterior zone II
 - Begins at the margin between zone I and zone II and extends into zone II for 2 disc diameters



Notch

- · An incursion by the ROP lesion of 1-2 clock hours into a more posterior zone.
- e.g., "zone I secondary to notch"



Aggressive ROP

- Aggressive-Posterior ROP (AP-ROP)
- NOW

Previously

- Changes to include areas beyond the posterior retina
- Larger preterm infants
 - Regions of the world with limited resources (Third Epidemic)



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Regression

- Regression can be complete or incomplete.
- Location and extent of peripheral avascular retina (PAR) should be documented.



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Reactivation

- ROP reactivation after treatment
 - New ROP lesions and vascular changes.
 - The modifier reactivated (e.g., "reactivated stage 2") is recommended

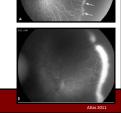






Long-Term Sequelae

- · Long-Term Sequelae.
 - Late retinal detachments
 - PAR
 - Macular anomalies
 - Retinal vascular changes
 - Glaucoma



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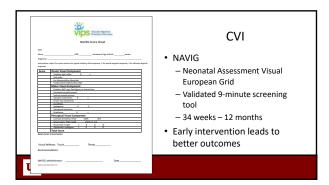
CVI – Cortical Visual Impairment

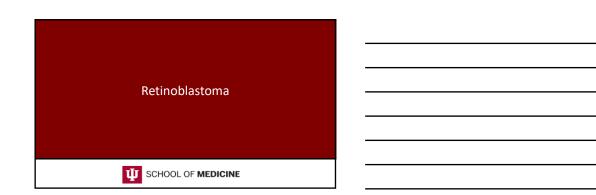
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CVI – Cortical Visual Impairment

- CVI is a leading cause of vision loss in US Children
 - NOT from problems with the EYE
- Associated co-morbidities
 - HIE, Prematurity, IVH, Genetic/neurologic conditions
- Can get better with time
 - Early intervention/therapy = Key
 - Educational support

CVI — Signs/Symptoms • Kids with CVI may have trouble: • Responding to the things they see • Seeing certain parts of what is in front of them, like busy moving scenes • Recognizing faces and objects • Reacgaizing things in cluttered spaces • Reaching for something while they re looking at IT • Understanding what they're looking at • Parents may also notice: • Reacts slowly to visual cues • Prefers to look at things in a certain part of their vision, like with their peripheral (side) vision • Some kids prefer: • Stare at light • Avoid lights





Retinoblastoma

- · Incidence on the rise
 - From 1/15,000 to 1/14,000 (Europe)
- Success rates increasing
 - Survival rate of 90%



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IAC: Intra-arterial Chemotherapy

- Started 1998
- More effective with Group D/E eyes compared to systemic chemo
- · Reduced overall treatment duration and less side effects compared with systemic chemo



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Before IAC..... and After SCHOOL OF MEDICINE

Intravitreal Chemotherapy

- Topotecan/Melphalan
- Extreme care
 - Avoid touching tumor
 - Freeze-thaw treatment



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