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The 728<sup>TH</sup> Meeting  
of  
**The New England Ophthalmological Society, Inc.**  
*A Public Foundation for Education in Ophthalmology*

**FEBRUARY 26, 2010**

**GLAUCOMA CHALLENGES**

*including*

THE RUTHANNE AND RICHARD SIMMONS LECTURE

James C. Tsai MD, MBA, Moderator

Joel Geffin MD, Program Committee Coordinator

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**EYE CARE IN THE DEVELOPING WORLD**

Paul R. Cotran, MD, Moderator

Susan MacDonald, MD, Program Committee Coordinator

**John B. Hynes Veterans Memorial Convention Center**  
**Third Level, Ballroom B**  
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## A MESSAGE FROM THE PRESIDENT

As I noted at the beginning of the current program year, NEOS has initiated and has continued to develop a “twinning” initiative between our Society and the Irish College of Ophthalmologists (ICO). The rationale of this association is to enhance the continuing medical education of members of both organizations, and to contribute to the stature of both NEOS and the ICO as leading national and international organizations in ophthalmology.

I am pleased to announce that the ICO has extended an invitation to all NEOS members to attend their 2010 Annual Conference, to be held in Dublin, April 28-30th. The meeting will cover diverse topics, including health care policy (which will lend perspective on our own domestic health care debate), glaucoma, uveitis, and a symposium on management of ocular melanoma. Social events will include golf, tennis, an evening at the Guinness Store House, and a black tie dinner with members of the RCSI (Royal College of Surgeons of Ireland).

If you are interested in travel to Ireland to attend the ICO meeting, hotel rooms have been reserved through the ICO at the Shelbourne Hotel and Buswells Hotel, both convenient to the meeting site in central Dublin. Aer Lingus, the Irish national airline, offers economical flights from Boston to Dublin and Shannon. Ireland is an interesting and beautiful country to visit, so please also consider staying for a few days before or after the meeting. For additional meeting information, hotel details and other inquiries, please refer to the NEOS website for links (<http://www.neos-eyes.org/>), or you may contact Judy Keenan at [neosjudy@aol.com](mailto:neosjudy@aol.com).

As you will no doubt note, the dates of the ICO meeting conflict with our own April 30th meeting – though this was unavoidable this year, we will make every effort to coordinate meeting dates with ICO to avoid this in the future.

I will look forward to seeing you in Dublin!

Charles Zacks, MD  
President

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## Guest of Honor



### **Garry P. Condon, MD**

Dr. Garry P. Condon is an Associate Professor of Ophthalmology at Drexel University College of Medicine and a Clinical Assistant Professor of Ophthalmology at the University of Pittsburgh. He is the Chairman of the Department of Ophthalmology at Allegheny General Hospital and the Director of the Glaucoma Division in the Department of Ophthalmology at Allegheny General Hospital in Pittsburgh, PA.

Originally from eastern Canada, he completed his residency in ophthalmology at the University of Western Ontario in London. He has done fellowships in ophthalmic pathology at McGill University in Montreal and in glaucoma and anterior segment surgery in Boston under the direction of Dr. Richard J. Simmons.

In 2001, Dr. Condon received the American Academy of Ophthalmology Honor Award. He has been listed in “The Best Doctors in America” on an annual basis since 2005 and he was recognized as one of “America’s Top Ophthalmologists” in the field of Cataract/Glaucoma Surgery by the Consumers’ Research Council of America in 2008. Dr. Condon continues to lecture nationally and internationally in the field of glaucoma and complex cataract surgery. In 2006 he was elected to membership in the International Intra-Ocular Implant Club. He serves on the American Academy of Ophthalmology’s Special Projects Committee as well as the American Society of Cataract and Refractive Surgery’s Glaucoma Clinical Committee.

He is currently in private and academic practice in Pittsburgh where for the last 21 years he has specialized in glaucoma and complex cataract and IOL surgery.



### **Alan L. Robin, MD**

Dr. Alan Robin is a leader in the clinical management and scientific study of glaucoma, and has for many years used his expertise to improve glaucoma detection and treatment in the developing world. Dr. Robin holds joint Associate Professorships in Ophthalmology and in International Health at Johns Hopkins University and is also a Clinical Professor at the University of Maryland. He is co-director of the Glaucoma Service at Sinai Hospital in Baltimore and

has an active glaucoma private practice with offices in the Baltimore and southern Pennsylvania areas.

Dr. Robin attended Yale University and Tufts University School of Medicine and completed his ophthalmology residency at Greater Baltimore Medical Center, followed by a fellowship in glaucoma at the Wilmer Institute. He was a HEED fellow and a recipient of two NIH R01 grants, and has been an active clinical investigator in initial studies of widely used glaucoma drugs including apraclonidine, latanoprost, brimonidine, and brinzolamide. Dr. Robin has published seminal articles on the use of lasers, drugs, and surgery for glaucoma treatment. His current research interests include the use of anecortave acetate as a treatment for open angle glaucoma and in improving adherence to topical glaucoma therapy. Dr. Robin has authored or co-authored over 170 peer-reviewed papers, 24 book chapters and given well over 100 invited lectures. He serves as editor or reviewer for numerous journals including Ophthalmology, Archives of Ophthalmology, the American Journal of Ophthalmology, and the Journal of Glaucoma. He has won many honors and awards during his career, among them the senior honor award of the AAO, and the Outstanding Humanitarian Service Award of the AAO in 2005. He is a member of the American Ophthalmological Society and was a founding member of the American Glaucoma Society. He is also a member of or consultant to international organizations including the International Association to Prevent Blindness, SEVA Foundation, Tissue Banks International, ORBIS International, and the World Health Organization. Dr. Robin has made over 50 trips to India and Nepal since the 1980s and worked closely with Dr. Venkataswamy, founder of the Aravind Eye Institute. He was instrumental in establishing its glaucoma service and still serves as its co-director. In recognition of his many contributions to eye care in South Asia, he has been elected as an honorary member of the Indian Glaucoma Society and the Nepal Ophthalmological Society.

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## Invited Guest Speaker



### **Geoffrey C. Tabin, MD**

Geoffrey Tabin is Professor of Ophthalmology and Visual Sciences at the University of Utah and the John A. Moran Eye Center in Salt Lake City, Utah and Co-Director of the Himalayan Cataract Project. He was the fourth person to climb the “7 Summits,” the highest point of all seven continents, and has pioneered difficult technical rock, ice, and mountaineering routes on all seven continents including the East Face of Mt. Everest. He is the author of

“Blind Corners – Adventures on Everest and the World’s Tallest Peaks” published by Lyons Press in October 2002.

Dr. Tabin is a graduate of Yale College, Oxford University (on a Marshall Scholarship) and Harvard Medical School. He completed a general surgery internship at The University of Colorado Hospitals, a residency in ophthalmology at Brown University and a corneal fellowship at Melbourne University in Australia. He then spent a year teaching eye surgery in Nepal. In 1994 he co-founded the Himalayan Cataract Project which strives to eradicate preventable and curable blindness in the Himalaya through high quality ophthalmic care, education, and establishment of a world-class eye care infrastructure.

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## RUTHANNE AND RICHARD SIMMONS GLAUCOMA LECTURE



In 2008, the Ruthanne and Richard Simmons Glaucoma Fund of the NEOS was established. The purpose of this fund is to promote quality glaucoma teaching, to help provide support for NEOS and to honor Ruthanne Simmons, MD (1959-2002), a glaucoma specialist, enthusiastic glaucoma teacher and active NEOS member. These purposes will be permanently implemented through a bi-annual glaucoma lecture at NEOS given by an internationally recognized glaucoma expert. When possible the fund may support other glaucoma related programs at NEOS.

NEOS is delighted that Dr. Garry P. Condon will be the second Simmons Lecturer.

Previous Simmons Lecturer:

2008 Joel Schuman, MD

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# Morning Session

## GLAUCOMA CHALLENGES

**Moderator: James C. Tsai, MD, MBA**  
**Program Committee Coordinator: Joel Geffin, MD**

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**Objective:** To present challenging conditions and describe innovative surgical approaches in patients with refractory glaucoma.

- 8:00 am** Registration/Exhibits/Continental Breakfast..... Ballroom C
- 8:30 am** Introduction ..... James C. Tsai, MD, MBA
- 8:35** Inflammatory Glaucoma: Which Surgical Approach? ... Sam P. Solish, MD
- 8:50** Zonule Problems in Pseudoexfoliation..... Garry P. Condon, MD
- 9:10** Cyclophotocoagulation: Current Status..... Marc L. Weitzman, MD
- 9:25** Business Meeting
- 9:40** Refreshment Break/Exhibits..... Ballroom C
- 10:10** Glaucoma Tube Shunt Surgery..... Geoffrey T. Emerick, MD
- 10:25** Schlemm’s Canal-based Surgery ..... Douglas J. Rhee, MD
- 10:40** THE RUTHANNE AND RICHARD SIMMONS LECTURE  
Is There Still a Role for Trabeculectomy?..... Garry P. Condon, MD
- 11:10** Panel Discussion..... James C. Tsai, MD, MBA  
*Moderator*  
Garry P. Condon, MD,  
Geoffrey T. Emerick, MD  
Douglas J. Rhee, MD  
Sam P. Solish, MD  
Marc L. Weitzman, MD
- 11:45** Luncheon Seminars (see page 30)

*Views expressed at NEOS meetings are not necessarily those of NEOS but represent the view of the individual speaker, without implied endorsement by NEOS.*

**EYE CARE IN THE DEVELOPING WORLD**

**Moderator: Paul R. Cotran, MD**

**Program Committee Coordinator: Susan MacDonald, MD**

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**Objective:** To discuss effective models and the role of volunteers in delivering eye care in developing countries; to present alternative techniques of cataract, cornea, and glaucoma surgery in places where access and cost of care are limiting factors.

- 1:00 pm** Introduction..... Paul R. Cotran, MD
- 1:05** ORBIS and Beyond: Modifying 21st Century Surgery  
for the Developing World ..... Aron D. Rose, MD
- 1:15** Eye Care in El Salvador: Partnering with a Local  
Non-governmental Organization (NGO)..... Douglas R. Scott, MD
- 1:25** The Aravind Eye Institute: A Vision Realized..... Alan L. Robin, MD
- 1:50** Lessons I Have Learned – Avoiding Pitfalls in  
International Ophthalmology..... Michael G. Morley, MD
- 2:00** Impossible Dreams – Everest and Eradicating Blindness  
in Nepal - The Himalayan Cataract Project.....Michael Wiedman, MD  
Geoffrey C. Tabin, MD
- 2:20** Refreshment Break/Exhibits ..... Ballroom C
- 2:50** Adventures in Cuban Ophthalmology over  
Two Decades .....Thomas R. Hedges III, MD
- 3:00** Screening and Treating Glaucoma in a  
Developing Country..... Alan L. Robin, MD
- 3:15** Ophthalmology in Persia and Afghanistan .....Michael W. Brennan, MD
- 3:25** Corneal Disease and Surgery in the  
Developing World ..... Geoffrey C. Tabin, MD
- 3:35** Panel Discussion ..... Paul R. Cotran, MD  
*Moderator*  
Michael W. Brennan, MD  
Thomas R. Hedges III, MD  
Michael G. Morley, MD  
Alan L. Robin, MD  
Aron D. Rose, MD  
Douglas R. Scott, MD  
Geoffrey C. Tabin, MD
- 4:00** Adjourn

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8:35 am

## INFLAMMATORY GLAUCOMA: WHICH SURGICAL APPROACH?

Samuel P. Solish, MD  
Eyecare Medical Group  
Portland, ME

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**Objective:** To discuss the surgical approaches to controlling intraocular pressure in uveitis related glaucoma.

Uveitis and the treatment of uveitis present particular challenges when secondary elevation in intraocular pressure occurs. Uveitis and steroid induced IOP elevation can be complex and involve multiple etiologies with unique pathophysiology. Control of intraocular pressure in uveitis related glaucoma may involve treatment of the underlying condition or may need to relate to the secondary effects of the uveitis (i.e. secondary angle closure) or the treatment (steroid induced glaucoma). If topical and systemic medications are ineffective or inadequate in controlling the intraocular pressure, glaucoma surgical treatment must be undertaken. The surgical approach and the long term outcome must be considered individually for each patient. Studies on the success rates of glaucoma surgery in primary open angle glaucoma may not be adequate to guide success in inflammatory glaucoma surgery.

Discussion will focus on the surgical planning for glaucoma surgery and outcomes related to glaucoma surgery in uveitis related glaucoma.

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### References:

Vuori ML. Molteno aqueous shunt as a primary surgical intervention for uveitic glaucoma: long-term results. *Acta Ophthalmol* 2009 Nov 7 (epub).

Papadaki TG, Netland PA, Foster CS. Long-term results of Ahmed glaucoma valve implantation for uveitic glaucoma. *Am J Ophthalmol* 2007;144(1):62-69.

Auer C, Mermoud A, Herbolt CP. Deep sclerectomy for the management of uncontrolled uveitic glaucoma: preliminary data. *Klin Monbl Augenheilkd.* 2004;221(5):339-42.

## ZONULE PROBLEMS IN PSEUDOEXFOLIATION

Garry P. Condon, MD  
Drexel University College of Medicine  
Pittsburgh, PA

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**Objective:** Understand the types of early and late cataract surgical complications in pseudoexfoliation and incorporate new surgical devices and techniques in their management.

The increased risk of complications in patients with pseudoexfoliation undergoing cataract surgery is well recognized. Studies suggest about a five times greater likelihood for capsule rupture, zonule dialysis and vitreous loss (1). These all appear to be related to the abnormal zonular laxity and weakness in pseudoexfoliation. This zonule pathology in conjunction with the advent of continuous capsulorhexis in the early 1990s is now associated with an incidence of late in-the-bag intraocular lens dislocation of about 1% (2). Considering the current volume of cataract surgeries performed, this translates into a substantial number of cases. Intraoperative capsule support devices and implantable rings or segments are now readily available but the timing of their insertion and their long-term benefit remain controversial (3). It is advantageous to understand and appreciate newly available surgical techniques and instrumentation to better manage the intraoperative and late postoperative problems in these patients (4).

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### References:

1. Shingleton BJ, Heltzer J, O'Donoghue MW. J Cataract Refract Surg. 2004;30(4):733.
2. Monestam EI. Ophthalmology. 2009;116(12):2315.
3. Ahmed I, Cionni R, Kraneman C, et al. Optimal timing of capsular tension ring implantation: Miyake-Apple video analysis. J Cataract Refract Surg. 2005;31(9):1809.
4. Gimbel HV, Condon GP, Kohnen T, et al. Late in-the-bag intraocular lens dislocation: incidence, prevention and management. J Cataract Refract Surg 2005;31(11):2193.

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**9:10 am**

**CYCLOPHOTOCOAGULATION:  
CURRENT STATUS**

Marc L. Weitzman, MD  
Ophthalmic Surgeons of Greater Bridgeport  
Fairfield, CT

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**Objective:** To present the modes of treatment, results, complications and case selection of cyclophotocoagulation.

Cyclophotocoagulation is often applied trans-sclerally, using a contact diode laser probe in eyes at high risk for surgical failure or eyes with limited visual potential. Over the past 2 decades an endoscopic delivery system has been developed to allow ab interno, directly visualized cyclophotocoagulation (ECP). Advantages of ECP are the ability to titrate treatment energy to a visual endpoint, less damage to adjacent tissues than trans-scleral laser and the ability to readily combine the procedure with phacoemulsification. Limitations include a limited ability to reduce IOP and the requirement to directly access the ciliary sulcus or vitreous cavity. A review of the literature will be presented as well as suggestions of cases where ECP may be useful.

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**References:**

Kahook MY, et al. One-site versus two-site endoscopic cyclophotocoagulation. *J Glaucoma* 2007;16(6):527-530.

Berke SJ. Endolaser cyclophotocoagulation in glaucoma management. *Techniques Ophthalmol* 2006;4:74-81.

## GLAUCOMA TUBE SHUNT SURGERY

Geoffrey T. Emerick, MD  
Consulting Ophthalmologists  
Farmington, CT

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**Objective:** To understand indications for, surgical techniques, and outcomes of tube shunt surgery.

While the number of trabeculectomies has declined over the past decade, the use of glaucoma tube shunts has increased. Both valved (Ahmed) and nonvalved (Baerveldt) shunts provide good long-term intraocular pressure (IOP) control in a broad range of clinical scenarios. An overview of surgical indications and techniques will be presented. The Ex-PRESS device, a modification of trabeculectomy surgery, will also be discussed. The Tube Versus Trabeculectomy Study compared the safety and efficacy of tube shunt surgery to trabeculectomy with mitomycin in 212 patients with previous surgery. At 3 years, mean IOP was 13.0 mm Hg in the tube group and 13.3 mm Hg in the trabeculectomy group with a mean of 1.3 and 1.0 medications, respectively. The probability of failure during the first 3 years was 15.1% in the tube group and 30.7% in the trabeculectomy group ( $P = .010$ ). Serious complications occurred in 24 patients (22%) in the tube group and 28 patients (27%) in the trabeculectomy group.

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### References:

Gedde SJ, Schiffman JC, Feuer WJ, et al. Three-year follow-up of the Tube Versus Trabeculectomy Study. *Am J Ophthalmol* 2009;148:670-684.

Tsai JC, Johnson CC, Kammer JA, Dietrich MS. The Ahmed shunt versus the Baerveldt shunt for refractory glaucoma II. Longer-term outcomes from a single surgeon. *Ophthalmology* 2006;113:913-917.

Kanner EM, Netland PA, Sarkisian SR, Du H. Ex-PRESS miniature glaucoma device implanted under a scleral flap alone or combined with phacoemulsification cataract surgery. *J Glaucoma* 2009;18:488-491.

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10:25 am

## SCHLEMM'S CANAL-BASED SURGERY

Douglas J. Rhee, MD  
Massachusetts Eye and Ear Infirmiry  
Boston, MA

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**Objective:** This presentation will describe the trabectome and canaloplasty procedures as well as present effectiveness and complication data from the peer-reviewed data.

Our current incisional drainage procedures for glaucoma (i.e. trabeculectomy and glaucoma drainage implants) consist of creating a full-thickness communication between the anterior chamber and subconjunctival space resulting in formation of a bleb. These procedures are generally effective and safe. However, improved reliability of effectiveness and decreased complication rates (short- and long-term) would be desirable.

This brief discussion will focus on the commercially available procedures. These newer procedures do not intentionally create a subconjunctival filtration area. Both involve creating a partial thickness removal of tissue, one from an ab interno approach (trabectome) and one from an ab externo approach (canaloplasty). To date, the evidence for both canaloplasty and ab interno trabeculotomy have demonstrated the ability to lower IOP. Both procedures can be effective when combined with phacoemulsification cataract extraction. On average, both procedures are associated with a lowering of IOP to the mid-teens from an average IOP in the low twenties.

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### Reference:

Minckler D, Mosaed D, Dustin L. Trabectome Study Group. Trabectome (trabeculectomy-internal approach): additional experience and extended follow-up. *Trans Am Ophthalmol Soc* 2008;106:149-160.

Lewis RA, von Wolff K, Tetz M, Korber N, Kearney JR, Shingleton B, Samuelson TW. Canaloplasty: circumferential viscodilation and tensioning of Schlemm canal using a flexible microcatheter for the treatment of open-angle glaucoma in adults: two-year interim clinical study results. *J Cataract Refract Surg* 2009;35:814-824.

THE RUTHANNE AND RICHARD SIMMONS LECTURE

## TRABECULECTOMY - IS THERE STILL A ROLE?

Garry P. Condon, MD  
Drexel University College of Medicine  
Pittsburgh, PA

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**Objective:** Understand the controversial current positioning of trabeculectomy as it relates to newer glaucoma surgical options in the management of glaucoma.

With the addition of newer glaucoma surgical devices and modifications along with new tube-shunt data, the ongoing role of conventional trabeculectomy surgery has recently been questioned. Long considered the ‘gold standard’ for intraocular pressure reduction, trabeculectomy is currently being challenged by canaloplasty and aqueous tube shunt surgery as its main contenders. For primary surgery canaloplasty with 2-year follow-up data has been suggested as a safer option. In eyes with previous surgery, the three-year follow-up data from the Tube versus Trabeculectomy study supports the Baerveldt 350 tube-shunt as a more effective alternative. Modifying the standard trabeculectomy technique by the placement of the Ex-PRESS shunt under the scleral flap has been reported to reduce the potential complication of postoperative hypotony. Despite newer devices, the historical efficacy of trabeculectomy and the recent trends in moving toward secure water-tight limbal incisions and broader mitomycin-C exposure for favorable bleb morphology, continue to keep trabeculectomy popular.

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Lewis R, von Wolff K, Tetz M, et al. Canaloplasty: Circumferential viscodilation and tensioning of Schlemm canal using a flexible microcatheter for the treatment of open-angle glaucoma in adults. Two-year interim clinical study results. *J Cataract Refract Surg* 2009;35(5):814.

Gedde SJ, Schiffman JC, Feuer WJ, et al. Three-year follow-up of the tube versus trabeculectomy study. *Am J Ophthalmol* 2009;148(5):670.

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1:05 pm

**ORBIS AND BEYOND:  
MODIFYING 21ST CENTURY SURGERY  
FOR THE DEVELOPING WORLD**

Aron D. Rose, MD  
Temple Medical Center  
New Haven, CT

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**Objective:** The speaker will briefly summarize his experience utilizing several eye care models used to combat blindness in the developing world.

Teaching medical and surgical ophthalmology in the developing world presents both unique challenges and gratifications to those of us who take on the challenge. Limited local funding, ophthalmic training and equipment, as well as a profound depth and range of pathology are among the primary obstacles facing the visiting physician. Various organizations attempting to address these problems have adopted differing approaches. The speaker will discuss his personal experience participating with models ranging from those utilized by Project Orbis, Unite for Sight, The Australian and New Zealand Eye Foundations, the Yale Department of Ophthalmology, and those developed on his own in India, China, Uzbekistan, Mongolia, the indigent Caribbean, the Himalayan Kingdom of Bhutan, Ghana and Myanmar.

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**References:**

Ruit S, Paudyal G, Gurung R, Tabin G, Moran D, Brian G. An innovation in developing world cataract surgery: sutureless extracapsular cataract extraction with intraocular lens implantation. *Clin Experiment Ophthalmol* 2000 Aug;28(4):274-9.

Sommer A. Global access to eye care. *Arch Ophthalmol* 2007 Mar;125(3):399-400.

Masnick K. Narrowing the gap between eye care needs and service provision: the service-training nexus. *Hum Resour Health* 2009 Apr 23;7:35.

**EYE CARE IN EL SALVADOR:  
PARTNERING WITH A LOCAL NON-GOVERNMENTAL  
ORGANIZATION (NGO)**

Douglas R. Scott, MD  
Laconia Eye and Laser Center  
Gilford, NH

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**Objective:** Describe how a sustainable eye care delivery system was created in Central America through the collaboration with a local NGO.

With any long term commitment to health care missions, the goal is to create a self-sustaining, high quality delivery system that will ultimately make the mission itself obsolete. ASAPROSAR was started 30 years ago to improve the lives of the very poor in this small Central American country. Among its programs is a specific eye care initiative that has grown from humble roots to a sophisticated effort that provides medical and surgical care. In partnership with a local NGO, the outreach has grown to serve thousands of patients in a comparatively modern free standing clinic. This presentation will consider the efforts and accomplishments of this enterprise and some of the challenges faced going forward.

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**References:**

Kansas PG, Sax R. Small incision cataract extraction and implantation surgery using a manual phacofragmentation technique. J Cat Refract Surg 1988:Vol. 14.

Umlas J, Cotran P. Eye care in El Salvador. Cataract and Refractive Surgery Today August 2006.

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1:25 pm

## THE ARAVIND EYE INSTITUTE: A VISION REALIZED

Alan L. Robin, MD  
Johns Hopkins University  
Baltimore, MD

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**Objective:** To present an example of a cost effective business model for treating eye diseases in the developing and developed world.

Imagine a health care system based on Ray Kroc's, the founder of McDonalds philosophy:

If one can make the same hamburger in Chicago, Boston, New Haven, and London with workers who may or may not show up; may not be motivated; cannot add or subtract to make change...then why can't one create a system in which one delivers the same quality of eye care in every corner of the globe.

The Aravind Eye Hospital was developed over 30 years ago by Dr. Venkataswamy in his retirement as a self-sustaining organization to eliminate needless cataract blindness. It was developed in a business model based upon compassionate capitalism, in which the poor would receive free care, those who could pay would pay what they could, and richer individuals would help support those who could not afford care. With the advent of good vision afforded by IOLs, the hospital decided to gamble and build its own IOL manufacturing factory. Today Aurolab makes 2 million IOLs per year, sutures, glaucoma shunts, latanoprost, and retinal gasses. Imagine in 30 years changing the cataract surgery rate from less than one in a million to over 6,000 per million (similar to the US).

Aravind's concepts of operation, its hospital, administration, school of community ophthalmology, optometry school, school of instrument repair, and manufacturing capabilities will be discussed. Aravind has become the preeminent cataract "factory" in the world. It has now turned to building institutions and to telemedicine to enable the rest of the developing world to better reduce needless blindness.

"Intelligence and capability are not enough. There must be the joy of doing something beautiful. Being of service to God and Humanity means going well beyond the sophistication of the best technology to the humble demonstration of courtesy and compassion to each patient."

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- Robin AL. Decreasing blindness in developing countries. *Ophthalmology* 1998;105:569.
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- Lee BW, Parthasarathi S, John RK, Singh K, Robin AL. Predictors of and barriers associated with poor follow-up among glaucoma patients in South India. *Archives of Ophthalmology* 2008;126:1448-1454.

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1:50 pm

## LESSON I HAVE LEARNED – AVOIDING PITFALLS IN INTERNATIONAL OPHTHALMOLOGY

Michael G. Morley, MD  
Ophthalmic Consultants of Boston  
Boston, MA

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**Objective:** To convey helpful lessons learned while running international ophthalmology projects.

Mistakes are painful but they are also powerful teachers. Here are a few lessons I've learned the hard way:

- 1) Having good intentions is a necessary, but not sufficient, condition for a good project. Meticulous planning, attention to detail, and careful consideration of every stakeholder are critical aspects of a well run project. Problems delivering 10,000 pairs of donated reading glasses highlight the importance of this lesson.
  - 2) A quiet but sustained project that makes a lasting difference in the host country is much more effective than a splashy onetime project. My experience developing an ophthalmology project in Thailand will be used to illustrate this lesson.
  - 3) The host country and doctors are the “stars of the show”- they are the ones delivering care long after you are gone. My experience working on a WHO funded Patient Safety project will be used to illustrate this point.
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### References:

Maki J, Kusakul S, Morley K, Sanguansak T, Seddon J, Hartung L, Morley M. The effect of glasses on visual function following cataract surgery in a cataract camp. Br J Ophthalmol 2008 Jul;92(7):883-7.

**IMPOSSIBLE DREAMS –  
EVEREST AND ERADICATING BLINDNESS IN NEPAL  
THE HIMALAYAN CATARACT PROJECT**

Geoffrey C. Tabin, MA, MD

Moran Eye Center; University of Utah School of Medicine  
Salt Lake City, UT

Michael Wiedman, MD

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**Objective:** Participants will understand the causes of blindness in Nepal, where we stand in the fight against each of these diseases, and how to set up a successful international eye care development program.

In 1994 Nepal, the poorest country in South Asia had the highest reported rate of blindness in the world. It was estimated that more than 300,000 people were blind with an additional 60,000 losing sight every year. Cataracts, untreated aphakia and complications of cataract surgery were responsible for more than 80% of blindness. In 1994 only 15,000 cataract surgeries were performed in this poor mountainous nation of 24 million people. Only ten percent of the surgical patients received IOLs.

The Himalayan Cataract Project was formed in 1995 and is dedicated to improving eye care through teaching and training at all levels and establishing self sustaining infrastructure for ophthalmic care. In 2009 surgeons in Nepal performed 200,000 cataract surgeries, 99% with IOLs. Sub-specialty eye care has also improved dramatically and The Program has expanded to Tibet, Bhutan and other areas of Asia and Africa.

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**References:**

Tabin G, Chen M, Espandar L. Cataract surgery for the developing world. *Curr Opin Ophthalmol* 2008 Jan;19(1):55-9.

Ruit S, Tabin G, Chang D. A prospective randomized clinical trial of phacoemulsification vs manual sutureless small incision extracapsular cataract surgery in Nepal. *Am J Ophthalmol* 2007 Jan;143(1):32-38.

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2:50 PM

## ADVENTURES IN CUBAN OPHTHALMOLOGY OVER TWO DECADES

Thomas R. Hedges III, MD  
New England Eye Center  
Tufts University  
Boston, MA

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**Objective:** To describe epidemic optic neuropathy that affected Cubans in the early 1990's and changes in ophthalmology in Cuba since then.

In 1992, an epidemic of optic and peripheral neuropathy began to affect many Cubans. This was not long after the Russians reduced aid to the island causing severe shortages, especially with regard to various foods. During this “Special Period in Time of Peace” the Castro regime reached out to various groups of physicians in part for advice, but also to demonstrate what was left of their health system. Tourism was also developing in order to provide some income. The exact cause of the epidemic was not determined, yet relations between some of those who traveled to Cuba grew. As Venezuelan money poured into Cuba in return for medical assistance, various medical services revived. This has been true especially in the field of ophthalmology where a younger generation of Cubans has been able to reconnect with the mainstream international medical community. It has been very rewarding to witness this development during multiple visits to Cuba over the last 17 years.

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### References:

Hedges TR III, Hirano M, Tucker K, Carballero B. Epidemic optic and peripheral neuropathy in Cuba: a unique geopolitical public health problem. *Survey Ophthalmol* 1997;41:71-83.

## SCREENING AND TREATING GLAUCOMA IN A DEVELOPING COUNTRY

Alan L. Robin, MD  
Johns Hopkins University  
Baltimore, MD

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**Objective:** To discuss the problems associated with the detection and screening of glaucoma in a developing nation and comparing it to the US.

Cataract is a relatively simple and inexpensive disease to diagnose and treat. All that is really needed to detect the disease is a hand light. Success rates approach 95%. Subjects begin symptomatic and disabled and return asymptomatic and functional. There is positive social marketing associated with cataract therapy with satisfied patients willingly spreading the word. Although a fully burdened cost of cataract surgery may be a one-time fee of US 50 (one months' salary) the costs can be recuperated soon and family member are glad to contribute, if possible. Glaucoma is totally different. Definitions are imprecise, there are no gold standards, and therapy creates symptoms in a previously asymptomatic patient. There is no perceived benefit in most patients to glaucoma therapy. Costs of medicines are chronic with no perceived benefit. Likewise, costs of machinery such as perimeters are high, and surgical devices such as shunts can be prohibitive for most. The author will discuss his 30 years of experience in India and Nepal, founding the glaucoma service at the Aravind Eye Care System. Detecting vs. screening, therapeutic options, costs of therapy, types of therapy will be discussed. A business model for treating glaucoma will be evaluated.

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### References:

- Natchiar G, Robin AL, Thulasiraj RD, Ravilla D, Krishnaswamy S. Attacking the backlog of India's curable blind: The Aravind Eye Hospital Model. *Arch Ophthalmol* 1994;112:987-993.
- Robin AL, Ramakrishnan R, Krishnadas R, Smith SD, Katz JD, Selvaraj S, Skuta GL, Bhatnagar R. A long-term dose response study of mitomycin C in glaucoma filtration surgery. *Arch Ophthalmol* 1997;115:969-974.
- Ramakrishnan R, Nirmalan PK, Krishnadas R, Thulasiraj RD, Tielsch JM, Katz J, Robin AL. Glaucoma in a rural population of southern India: The Aravind Comprehensive Eye Survey. *Ophthalmology* 2003;110:1484-1490.
- Krishnadas R, Nirmalan PK, Ramakrishnan R, Thulasiraj RD, Katz J, Tielsch JM, Robin AL. Pseudoexfoliation in a rural population of southern India: The Aravind Comprehensive Eye Survey. *Am J Ophthalmol* 2003;135: 830-837.
- Robin AL, Nirmalan PK, Krishnadas R, Ramakrishnan R, Katz J, Tielsch J, Thulasiraj RD. The utilization of eye care services by persons with glaucoma in rural south India. *Trans Am Ophthalmol Soc* 2004;47-56.
- Lee BW, Parthasarathi S, John RK, Singh K, Robin AL. Predictors of and barriers associated with poor follow-up among glaucoma patients in South India. *Arch Ophthalmol* 2008;126:1448-1454.

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3:15 pm

## OPHTHALMOLOGY IN PERSIA AND AFGHANISTAN

Michael W. Brennan, MD  
American Academy of Ophthalmology  
San Francisco, CA

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**Objective:** Understand the complexities of being an ophthalmologist in either Iran or Afghanistan.

Health care, including ophthalmology's role, exists in a remarkable diversity of presentations in the Middle East and Southwest Asia--as opposed to relative uniformity in Latin America and even Sub Saharan Africa. This discussion will focus on the structure and function of physician organizations in several representative Middle East and southwest Asia nations. The balance of influence between "Associations" and "Ministries" will be illustrated and winning ways for physicians to lead and serve will be accented.

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### References:

Personal travel

State Department Grant

AAO Global Alliance experience

## CORNEAL DISEASE AND SURGERY IN THE DEVELOPING WORLD

Geoffrey C. Tabin, MA, MD

Moran Eye Center; University of Utah School of Medicine  
Salt Lake City, UT

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**Objective:** The audience will understand the causes of corneal blindness in our world and the difficulty with corneal surgery in developing nations.

Corneal disease is the second leading cause of blindness in our world. Most is infectious in nature and can be prevented. However, prevention of blindness from bacterial and fungal keratitis is complicated and difficult in poor countries due to poor access to care and difficulty and expense in obtaining medications. Similarly trachoma, onchocerciasis and xerophthalmia need to be prevented by improved access to clean water, improved diet and distribution of medications.

Corneal surgery in the developing world is difficult due to a lack of donor tissue, poor patient follow up and the cost of post-operative medications. Glycerine preserved corneal tissue, lamellar corneal surgery and early intervention are improving outcomes of corneal surgery in Nepal and Africa.

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### References:

Tabin GC, Gurung R, Paudyal G, Reddy HS, Hobbs CL, Wiedman MS, Ruit S. Penetrating keratoplasty in Nepal. *Cornea* 2004 Aug;23(6):589-96.

Ruit S, Tabin G, Gurung R, Shattuck T, Murchison A, Dimmig J. Temple eye banking in Nepal. *Cornea* 2002 May;21(4):433-4.

## Summary of Financial Disclosure Information

As a sponsor accredited by the Massachusetts Medical Society, NEOS must ensure balance, independence, objectivity, and scientific rigor in all its individually sponsored and jointly sponsored educational activities. All faculty participating in a sponsored activity are expected to disclose to the activity audience any discussion of off-label use or investigations use of a product, and any significant financial interest or other relationship which they, or their spouse/partner, have (1) with the manufacture(s) of any commercial product(s) and/or provider(s) of commercial services discussed in an educational presentation and (b) with any commercial supporters of the activity. (Significant financial interest or other relationship can include such things as grants or research support, employee, consultant, major stockholder, member of speaker's bureau, etc.).

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Faculty	Name of Organization	Consulting Fees	Contracted Research	Speaker's Bureau	Ownership (stock, etc.)	Other Financial Interest (salary, royalties)
Brennan, Michael	N/A					
Condon, Garry	Alcon Optonol Allergan	X X		X X X		
Emerick, Geoffrey	N/A					
Hedges, Thomas	N/A					
Morley, Michael	N/A					
Rhee, Douglas	Alcon Allergan Pfizer	X X	X X X			
Robin, Alan	N/A					
Rose, Aron	N/A					
Scott, Douglas	N/A					
Solish, Sam	N/A					
Tabin, Geoffrey	N/A					
Weitzman, Marc	N/A					

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Faculty	Name of Organization	Consulting Fees	Contracted Research	Speaker's Bureau	Ownership (stock, etc)	Other Financial Interest (salary, royalties)
Arroyo, Jorge	Pfizer	X				
Bajart, Ann	Becton Dickenson, TBI-Medical Director, NE Eye Bank	X				X
Bradbury, Michael	N/A					

## Financial Interests or Relationships (continued)

Faculty	Name of Organization	Consulting Fees	Contracted Research	Speaker's Bureau	Ownership (stock, etc)	Other Financial Interest (salary, royalties)
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Cotran, Paul	N/A					
Daly, Mary	N/A					
DuBoff, Stuart	N/A					
Elliott, Alexandra	N/A					
Geffin, Joel	N/A					
Gilbert, Mitchell	N/A					
Hatton, Mark	Becton Dickenson	X				
	McKesson	X				
Heier, Jeffrey	Acucela	X				
	Alcon Labs	X	X			
	Alimera		X			
	Allergan	X				
	Fovea	X				
	Genentech	X	X			
	Genzyme	X				
	Heidelberg	X		X		
	iScience	X				
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	Jerini		X	X		
	Neovista	X	X			
	Neurotech	X	X			
	Novagali	X	X			
	Oraya	X				
	Paloma	X				
	Pfizer	X				
	Potentia	X				
	Regeneron	X	X	X		
	Schering Plough Research Institute		X			
Hill, David	N/A					
Kahn, Natan	N/A					
Miller, Joan	QLT Pharm					X
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	Genzyme	X				
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Soares, Chris	N/A					
Spindel, Gerald	N/A					
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	Allergan			X		
	Optimedica	X		X		
Tsai, James	Allergan	X				
	Merck	X				
	Pfizer	X				
Weinberg, David A	N/A					
Wilbanks, Garth	N/A					
Woodcome, Harold	N/A					
Zacks, Charles	N/A					

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## Luncheon Seminars

Please register for luncheons online at [www.neos-eyes.org](http://www.neos-eyes.org) with payment by credit card. You will receive an email receipt, which will be your entry ticket into the seminar. ***Be sure to print and bring the receipt with you.*** Should you not have access to online registration, please fax your selection to 617.367.4908 no later than FRIDAY, February 19<sup>th</sup> – requests received after that date cannot be accepted. Limited, if any, requests can be accepted on site prior to the morning refreshment break only.

The fee for luncheon seminars is \$35.

I. **Topics in International Ophthalmology**

Alan L. Robin, MD

II. **Case discussions in Normal Tension Glaucoma**

James C. Tsai, MD

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## Accreditation

The New England Ophthalmological Society designates this educational activity for a maximum of *7 AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The New England Ophthalmological Society is accredited by the Massachusetts Medical Society to provide continuing education for physicians.

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## Evaluation Forms/Certification of Attendance

CME evaluation forms will be provided at the time of registration. Attendees are encouraged to evaluate each presentation and to identify the effectiveness with which the educational goals were met. Suggestions for improvement of future educational program and the identification of specific educational needs are encouraged.

**To receive a certificate, you must complete and submit the evaluation form.**

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## Candidates Proposed for Membership

<b>CANDIDATE</b>	<b>PROPOSED BY</b>	<b>SECONDED BY</b>
Christine S. Ament, MD Boston, MA	John Gittinger, MD Boston, MA	Milhim Aswad, MD Dedham, MA
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Mitesh Kapadia, MD Boston, MA	Katrinka Heher, MD Boston, MA	Alexandra Elliott, MD Boston, MA

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## Proposal of New Members

We would like to remind all members to encourage and sponsor nonmembers to join the Society. Please keep us informed of new ophthalmologists who may move into your area so that we can invite them to attend meetings and join when eligible.

1. The proposed candidate must be Certified by the American Board of Ophthalmology or the Fellows of the Royal College of Surgeons (Canada) in Ophthalmology.
2. The proposed candidate must have resided and/or practiced ophthalmology in New England for two years prior to being nominated.
3. A member of the Society must nominate the proposed candidate at a Business Meeting.
4. A member of the Society must second the nomination.
5. Sponsors may download the nomination form on-line ([www.neos-eyes.org](http://www.neos-eyes.org)) to be completed and turned in at the Business Meeting at the time of nomination of the candidate.
6. An application form, which will be sent to the candidate following nomination, must be completed by the candidate and forwarded to the Chair of the Admissions Committee: Gerald Spindel, MD, NEOS, PO Box 9165, Boston, MA 02114.
7. The sponsoring and seconding members to the Chair of the Admissions Committee must submit letters of recommendation.
8. The Candidate's name will then be circularized to the entire membership for comments pro and con admission.
9. The Chair of Admissions Committee will ascertain that the candidate is a diplomat of the American Board of Ophthalmology and evaluate any comments received.
10. The Admissions Committee submits recommendations to the Executive Board.
11. After approval by the Executive Committee, the candidate's name will be published in the program and be voted upon at a meeting of the membership.
12. Membership commences with payment of dues.

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## Committee Meetings

1. Executive Board and Committee Chairpersons  
Thursday, February 25, 5:00 pm, Downtown Harvard Club
2. Public Health and Education Committee  
Friday, February 26, 7:30 am, Room 301, Hynes Convention Center
3. Ophthalmic Services Committee  
Friday, February 26, 11:45 am, Room 305, Hynes Convention Center
4. Program Committee  
Friday, February 26, 11:45 am, Room 308, Hynes Convention Center

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## Scientific Session Registration Fees

CATEGORY.....	FEE
Active Members .....	None
Retired Members .....	None
Medical Students, Interns, Residents, Fellows .....	None
Non-members within two years of completion of a <u>residency</u> (letter from Chairman of the Residency Program required).....	None
Inactive Member.....	\$235.00
Non-Members (except as above).....	\$235.00

If a nonmember becomes an active member *during the first fiscal year* in which he has paid nonmember fees to attend a meeting, the amount paid will be subtracted from the first year's dues.

Ophthalmic Medical Personnel .....	\$35.00
(assistant, technicians, technologists, nurses, photographers, administrators)	

Registration fees must be paid in advance or on the day of the meeting. You may preregister online and pay by credit card at [www-neos-eyes.org](http://www-neos-eyes.org) - **credit cards cannot be accepted on site**, checks or cash only. Fees not paid 10 days after the meeting are subject to increase.

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## Attendance, Registration and Identification Cards

1. Attendance and nametags are computer generated. Members must bring their permanent nametag to each meeting to check in electronically. If you do not have your card with you, you will need to obtain a temporary card to scan in. On site registrants will receive a temporary 'guest' nametag for that day only. BE SURE TO SCAN IN FOR BOTH THE MORNING AND AFTERNOON SESSION to obtain credits for each session.
2. The appropriate NEOS badge labeled "MEMBER" or "GUEST" or "EXHIBITOR" must be worn for entry into the auditorium.

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## Participating in Scientific Sessions of the New England Ophthalmological Society

The New England Ophthalmological Society encourages broad participation in its educational programs.

Please review the listing of future NEOS meetings and topics. Submit abstracts no later than four months prior to the meeting. The abstract form is available online at [www.neos-eyes.org](http://www.neos-eyes.org).

Send new ideas and suggestions anytime to:

David Lawlor, MD  
Chair, Program Committee  
212 Prouty Drive, Ste. 2  
Newport, VT 05855  
802/334-8002  
[dlawlor@nchsi.org](mailto:dlawlor@nchsi.org)

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## Future NEOS Meetings – John Hancock Hall (unless noted)

*The NEOS Program Committee recognizes and appreciates the work of all moderators.*

DATE	TOPICS	MODERATOR
April 30, 2010	Oculoplastics Neuro-ophthalmology	Natan Kahn, MD Dean Cestari, MD
June 4, 2010 POSTER CONTEST	Retina Subspecialty Sessions (glaucoma/cornea/retina)	Harold Woodcome Jr, MD Christopher Soares, MD
October 1, 2010	Ethics and Risk Management Cornea/Refractive	Gregory McCormick, MD Roberto Pineda, MD
December 3, 2010 Hynes Convention Center	Office Efficiency Cataract	Gerald Spindel, MD Carolyn Anderson, MD
March 4, 2011	Oculoplastics Subspecialty Sessions	Michael Migliori, MD
April 15, 2011	Glaucoma Cataract	Teresa Chen, MD Joseph Williams, MD
May 20, 2011	Retina Ophthalmic Emergencies	Nauman Chaudry, MD David Lawlor, MD

### **NEOS SCIENTIFIC POSTER PROGRAM Hecht Awards for Best Resident and Fellow Posters June 4, 2010**

Residents and fellows from all the New England ophthalmologic teaching programs are invited and encouraged to submit abstracts for a scientific poster presentation contest to be conducted at the June 4, 2010, NEOS meeting. Posters will be judged on originality and scientific merit, and awards will be made for the first prize \$500.00, second prize \$300.00, third prize \$200.00 and three honorable mentions of \$50.00 each. Funding for the awards is derived from a gift to the NEOS Education Endowment Fund honoring the late Sanford Hecht, MD. Poster presentations exhibited at ARVO in 2010 and at the AAO meeting in of 2009 may be submitted. We encourage all trainees to participate in this event.

To submit posters, go to [www.neos-eyes.org](http://www.neos-eyes.org) - meetings/abstract submission form. For questions, contact Judy Cerone Keenan at 617/227-6484 or [neosjudy@aol.com](mailto:neosjudy@aol.com)

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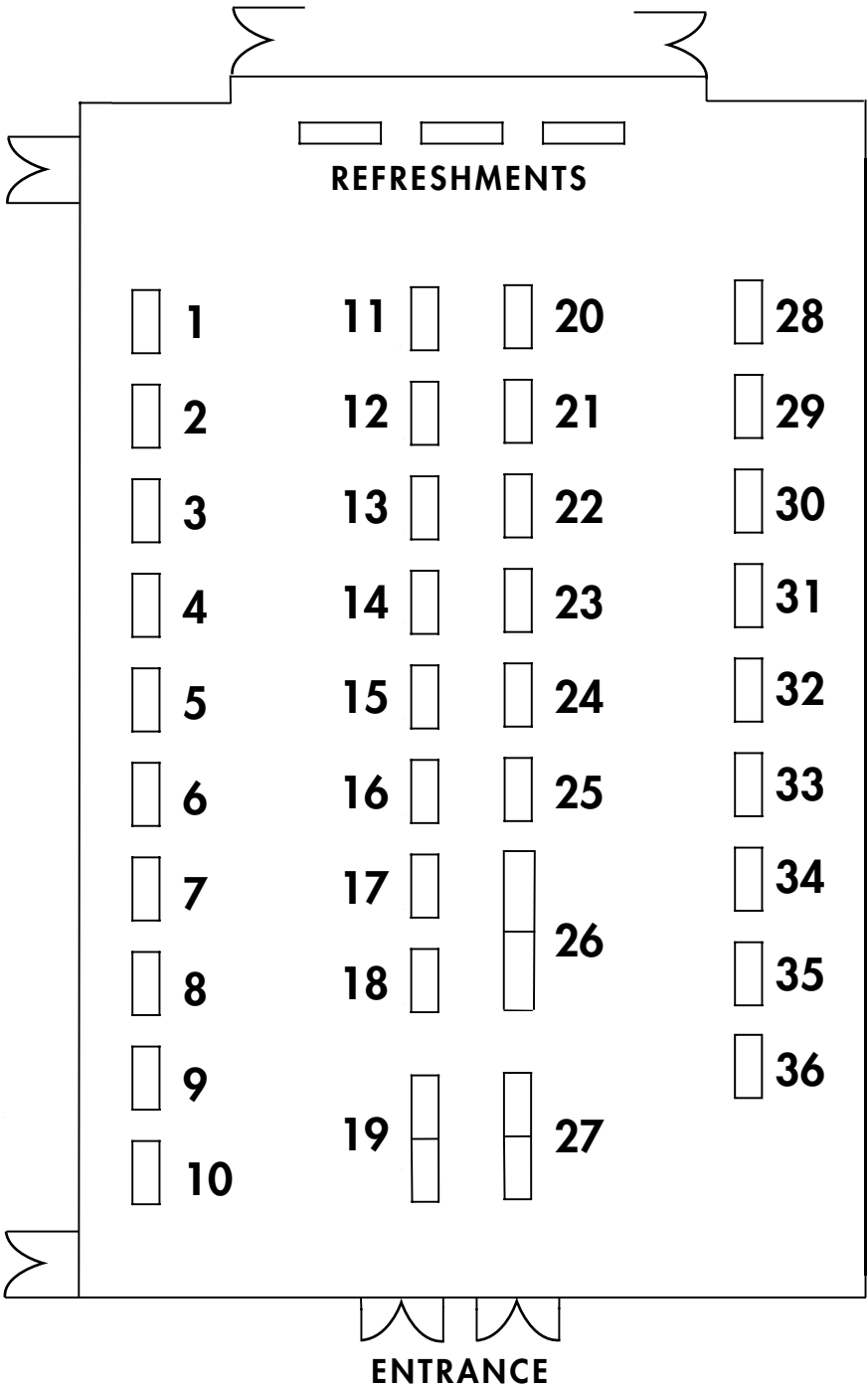
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## **Public Transportation**

The Hynes Convention Center can be reached by taking the MBTA Green Line and getting off at the Hynes Convention Center/Auditorium Station.

**IN MEMORIAM**

Richard S. Luftman, MD

1948-2009

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