



CO-MANAGEMENT



HORIZON EYE SPECIALISTS
& LASIK CENTER

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Shelby and her staff will assist you with forms, business cards, and literature for your office. She is also the contact to fax pre-op/post-op letters.

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- Please direct any medical questions to Dr. Lambert, or you may contact one of our other doctors listed below.

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Co-Management Manual

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The Purpose of this Manual

At Horizon Eye Specialists and Lasik Center (HESLC), we sincerely thank you for allowing us to participate in the care of your patients. We believe that the best care your refractive and cataract surgery patient can receive is from a co-management approach. We are dedicated to providing the best surgical care and the latest technology working with you, the referring optometrist.

Horizon Eye Specialists & Lasik Center (HESLC) makes every effort to provide the best in sight-enhancing and preservation services. Our surgeons maintain constant vigilance over new methods and technologies. We are currently using the IntraLase® Laser and VISX® Star S4 Excimer Laser System with its state-of-the-art wavefront guided treatment and iris registration. Additionally, we implant the Verisyse® Phakic IOL for highly myopic patients and we perform Conductive Keratoplasty, a safe radio frequency procedure for presbyopic patients. Finally, cataract surgery and clear lensectomy with new FDA-approved multifocal intraocular lenses gives us an unprecedented ability to restore distance and near vision. This co-management manual has been prepared to guide you and your staff through the preoperative and postoperative process for each of the above procedures.

Not only do we value the latest in technology and surgical techniques, but we also emphasize a personalized approach to each and every patient. Each patient will meet his or her surgeon for a complete consultation prior to surgery.

The HESLC co-management program is dedicated to building relationships through continual communication and support with you and your staff. To this end, we provide all of the essential tools needed to make your practice co-management friendly: informational brochures, pre-and-postoperative examination forms, DVDs of procedures, staff training and medical education seminars, laminated visuals, in-house patient seminars, patient outsourcing, and financing for your patient's procedures.

We appreciate your confidence in allowing us to provide surgical care for your patients. Thank you again for your partnership. If you have any questions or comments, please contact one of our co-management consultants at the numbers listed below:

Shirley J. Lambert, O.D. Co-management Director
Shelby Bogaard Co-management Coordinator

Main# 602-HORIZON or 602-467-4966

Fax# 480-419-5401 (pre- and post-operative forms are to be faxed to this number)

Note: our surgeons also do a wide range of other surgical procedures (corneal transplants, DSAEK, PTK, trabeculectomy, ALT, LPI, pterygium removal, chalazion excision, etc.). This manual will only discuss surgeries directly related to pre- and post-operative surgical co-management. Please call if you would like more information regarding the other services we provide.

The Role of the Co-managing Doctor

As the patient's primary eye care provider, you have the most comprehensive knowledge and understanding of your patient's visual needs and motivations for surgery. Refractive and cataract surgery candidates should be educated that continued primary eye care is necessary even after vision correction procedures.

A quality and consistent surgical experience begins with the co-managing optometrist's understanding of the surgical process as well as the options and treatments that a patient may receive upon referral to Horizon Eye Specialists & Lasik Center.

The role of the primary eye care provider is:

- **To select the appropriate candidate for refractive or cataract surgery**
- **To provide information, educate and counsel their patients**
- **To simulate monovision preoperatively with the use of contact lenses, where applicable**
- **To perform manifest and cycloplegic refraction prior to the procedure, where applicable**
- **To monitor patients at specific intervals and to report findings**
- **To reassure, comfort, and support patients whose expectations exceed the natural healing process**
- **To continue to monitor the health of the patient's eye during the aging process, aside from any refractive procedural considerations**
- **To assist presbyopic patients with near vision needs**

Refractive Surgery: The Procedures

iLASIK (LASIK with Intralase)

The IntraLase® Method uses tiny, rapid pulses of laser light to create your corneal flap—instead of using a metal blade—during the first step of LASIK. Each pulse of light passes through the top layers of your cornea and forms a microscopic bubble at a specific depth and position within your eye that is determined by the doctor. The IntraLase® laser moves back and forth across your eye, creating a uniform layer of bubbles just beneath your corneal surface. Just prior to applying laser vision correction, the doctor creates your corneal flap by gently separating the tissue where these bubbles have formed. The corneal flap is then folded back so the doctor can perform the second step of your LASIK treatment.

Advanced Surface Ablation (PRK, LASEK or epi-LASIK)

Advanced Surface Ablation (ASA) describes a collection of techniques [including photorefractive keratectomy (PRK) and laser subepithelial keratomileusis (LASEK) or epi-LASIK] in which no stromal flap is created. The epithelium is gently removed by one of several techniques (hence the different names), and an excimer laser sculpts the surface of the cornea. Wavefront technology is also used. With a similar treatable range of refractive error as LASIK, advanced surface ablation techniques are safer for patients with thin or irregularly-shaped corneas. Although the initial visual recovery is slower and less comfortable than LASIK, the long-term visual outcomes are equally as excellent as LASIK. At HESLC, the ASA procedure most commonly used is PRK.

Conductive Keratoplasty

Conductive Keratoplasty (CK) is a procedure used for the treatment of low degrees of hyperopia and presbyopia. CK applies radiofrequency energy to the peripheral cornea, resulting in a steepening of the central cornea. Discomfort is minimal, and visual recovery is rapid. Since the treated collagen can remodel with time, and since presbyopia increases with age, the procedure may need to be repeated every few years.

Phakic Intraocular Lenses (or Implantable Contact Lenses)

Phakic intraocular lenses (IOLs) are artificial lens implants that are placed inside the eye while the patient's natural lens remains intact. Ideal candidates for phakic IOLs are high myopes with thin or irregular corneas who would be poor candidates for laser refractive surgery.

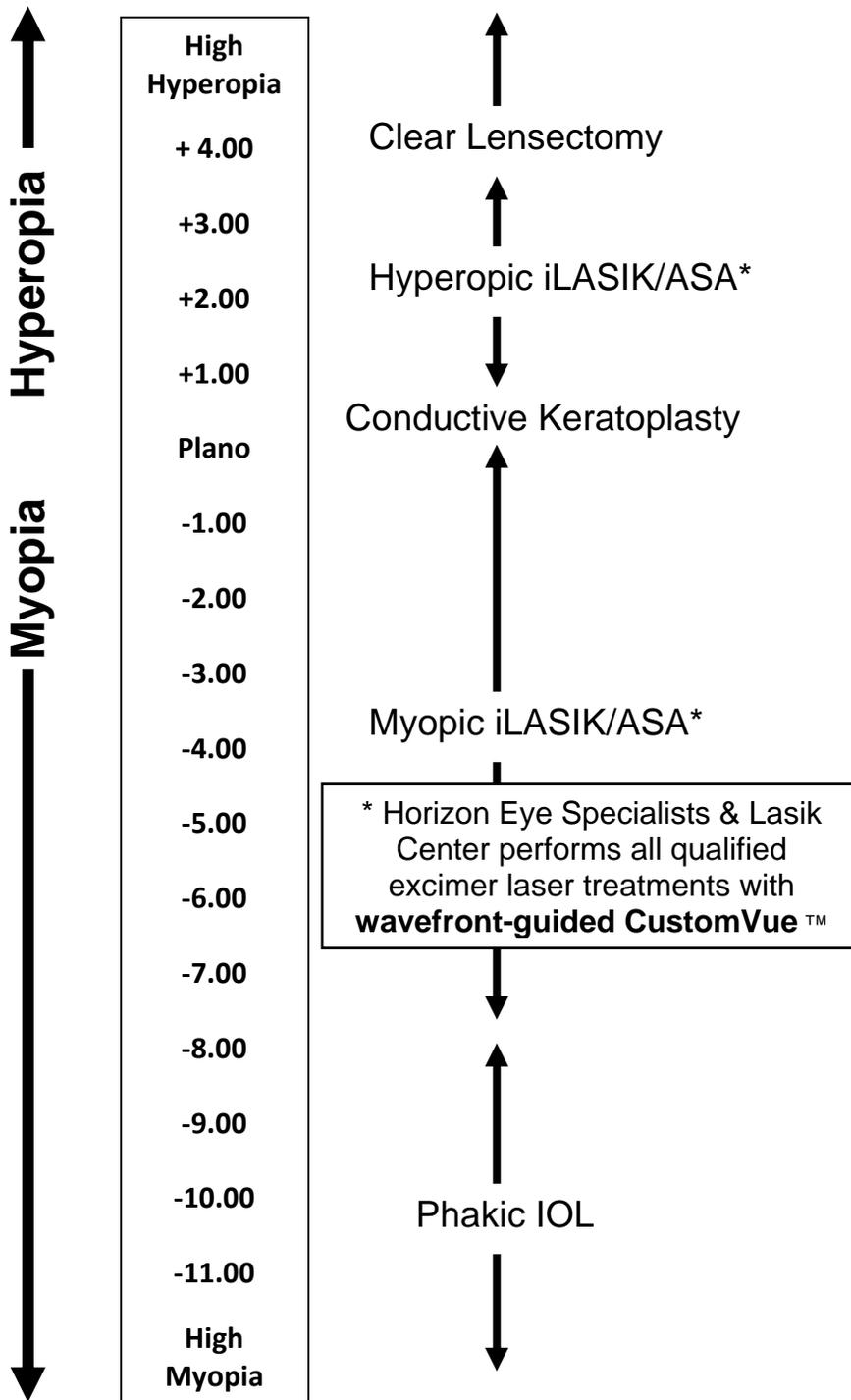
Clear Lensectomy

Clear lensectomy (natural lens replacement or refractive lens exchange) involves removal of the crystalline lens and replacement with an intraocular lens (IOL). Ideal candidates are presbyopic hyperopes. With multifocal and accommodative IOLs, clear lensectomy can give excellent uncorrected distance and near vision.

Limbal Relaxing Incision (LRI)

This radial keratotomy-type procedure is still occasionally used as a stand alone treatment for patients whose only refractive error is minor corneal astigmatism, most typically residual astigmatism following a previous refractive surgery.

Refractive Surgery: The Procedures



This diagram serves as a general guideline only. The actual procedure and treatment plan selected will be individually determined for each patient based on a composition of factors which include (but are not limited to) refractive error, age, corneal thickness, and lifestyle

Refractive Surgery: Patient Selection

Patient Selection

The key to a happy refractive surgical patient begins with good patient selection. A patient's candidacy for refractive surgery involves not only eye-related objective measurements (refractive error, corneal thickness, etc.) but also non eye-related subjective factors (patient goals and expectations). Because of your role and experience in caring for the unique visual needs of each of your patients, you are uniquely positioned to provide the best insight as to the qualifications of someone as a candidate for a refractive procedure.

Patients are most likely to be happy with the results of refractive surgery if they have a specific and realistic objective in mind. A specific objective creates an end point, which marks the success of the procedure for the patient. A realistic objective is one that we can achieve with the currently available technology. Patients with unrealistic demands such as "perfect vision" or total spectacle independence will probably not be satisfied until perfection is achieved. Patients without a specific occupational, sports, or hobby related objective, must be carefully educated as to the limitations of a refractive procedure so that their expectations are reasonable.

Motivation:

Reasons for considering refractive procedure:

- Occupational
- Recreational
- Cosmetic
- Emergency situations

Be careful when selecting and counseling a refractive candidate; if someone desires perfection, consider this a red light for possible future problems.

Questions:

Questions that will assist you in selecting good candidates for a refractive procedure:

- Does the patient have realistic, well-defined goals and expectations?
- Is the patient willing to accept some risk that their objective might not be achieved?
- Is this patient able to understand the concept of risk/benefit ratio?

Refractive Surgery: Preoperative Care

Pre-Procedural Examination and Measurements

Medical History:

A complete medical history should be performed, with special emphasis on the following:

- Allergies, including drug allergies
- Systemic diseases: diabetes mellitus, collagen vascular disease, or immunocompromise of any etiology is a relative contraindication
- Medications contraindicated in excimer laser surgery
 - Isotretinon (Accutane)
 - Amiodarone (Cordarone)
 - Sumatriptan (Imitrex)—relative contraindication
- Pregnancy and lactation are contraindications.

Ocular History:

A complete ocular history should be performed, with special emphasis on the following:

- Previous and existing ophthalmic conditions (glaucoma, strabismus, amblyopia, corneal dystrophy, and dry-eye syndrome), previous ocular surgery or trauma, and previous history of herpes zoster and herpes simplex.
- Stability of refraction: The patient must be at least 18 years of age, and two refractions (one year apart) must be stable to within 0.50 D.
- Contact lens history:
 - **Soft contact lenses** should be removed **at least 3 days** prior to testing and surgery.
 - **Toric lenses** should be removed **at least 1 week** prior to testing and surgery.
 - **Hard or Gas permeable lenses** should be removed at least **3 weeks** (or longer) prior to testing and surgery.If any change or distortion is noted, it will be necessary to leave the lenses out for a longer period of time until the refraction and/or topography show stabilization.

Refraction:

Complete a thorough manifest and cycloplegic refraction to provide a basis to calculate surgical parameters. Note: refractions for refractive surgery differ somewhat from refractions for glasses or contact lenses -

- **Fogging technique** should be utilized to minimize the myopic sphere.
- The cylinder should be maximized using the Jackson Cross-Cylinder technique.
- Cycloplegic refraction is necessary to ensure that a significant accommodative component is not present. For the average accommodating patient, 1% tropicamide is sufficient. For latent hyperopes or patients with strong accommodative systems, use 1% cyclopentolate at least three days prior to surgery.

- Patients with BVA less than 20/20 warrant closer evaluation. If the eyes appear normal (no corneal scars, cataracts, retinal problems, etc.) consideration should be given to irregular astigmatism (a rigid contact lens over-refraction would rule this out), keratoconus, or contact lens-induced corneal warpage. Patients with limited BVA preoperatively should be aware they will have BVA limitations after surgery.

Keratometry:

Patients with extreme keratometric values outside the normal range of 39-48 diopters should be carefully evaluated. Steep corneas are suspicious for keratoconus. Irregular keratometry mires and flatter corneas may suggest contact lens warpage.

Presbyopia:

If indicated, discuss presbyopic issues. Likewise, determine ocular dominance and perform a trial fitting of contact lenses if the patient is considering monovision.

Slit Lamp Examination:

A complete slit lamp examination should be performed. Particular attention should be paid to the cornea and the lens.

- **Cornea:** Note any previous scars/opacities, especially those suspected of being herpetic in origin. Herpes virus may be reactivated by corneal surgery. Look for signs of keratoconus. Note any signs of anterior/epithelial basement membrane dystrophy.
- **Lens:** Note significant lenticular opacities. Patients with visually significant cataracts (or early lenticular changes) should consider cataract surgery or lensectomy instead of corneal refractive surgery.

Retinal Evaluation:

A dilated fundus examination should be performed to evaluate for retinal pathology, including macular disease and peripheral retinal pathology. The patient must understand that the risk of retinal detachment does not decrease simply because the dependence on glasses decreases. Annual examinations by the primary eye care physician are still required and must be emphasized.

Refractive Surgery: Preoperative Care

Patient Counseling by the Co-managing Optometrist

Once the patient is well informed about the benefits and the limitations of a refractive procedure, the following should be discussed:

- Clinical findings and their eye condition.
- The various refractive options based on their age and refractive error.
 - A thorough explanation of presbyopia and the possibility of monovision.
- The treatment procedure recommended.
 - The risks and complications of that procedure.
 - The time involved for visual recovery after the recommended procedure.
 - The side-effects of the procedure, including dryness and visual fluctuation.
- The post treatment medications and follow-up schedule.
- Reasonable expectations.
 - The possible difficulties with night driving.
 - The possible need for glasses or contact lenses after treatment.
- The upcoming interaction that will take place between the patient and the surgeon.
- How the postoperative care will be co-managed.

Consultation at HESLC:

Our goal in the consultation process is to make the patient feel as comfortable at our facility as they do at yours. It is our commitment to the patient as well as to you, the referring doctor, that your patient has a wonderful experience.

- Your patient should expect to spend about **1.5 – 2 hrs** with the surgeon and the refractive team.
- The patient's chart will have the preoperative consultation form from your office. If we do not have the form, we will call to request a copy of the form.
- Wavescan, corneal topography, and corneal pachymetry will be performed.
- The surgeon will meet and examine the patient, at which time the patient's candidacy and the best refractive procedure will be determined.
 - Monovision will be discussed, if appropriate.
- The patient is informed of what to expect before, during, and after surgery.
- The patient will then meet with the refractive surgery coordinator.
 - The co-management process is explained (how postoperative follow-up will be arranged).
 - Cost and payment options are discussed.
 - The patient is scheduled for surgery. If a patient does not schedule surgery, the refractive surgery coordinator will confirm the reasons and make a follow-up call in the near future.
 - After the consultation visit, notes and plans will be faxed or mailed to your office. Notes will also be faxed after the 1 day postoperative visit.

Refractive Surgery: Risks and Complications

iLASIK or ASA

Visual Outcomes:

We have found our results in line with that of the FDA clinical trials for the Visx® Star S4 laser, in which 98% of eyes were 20/20 or better and 70% of eyes were 20/16 or better at 12 months. In this group of patients with less than 6.00 D of MRSE and 3.00 D of cylinder, 93% of patients were within ± 0.50 D of emmetropia. Likewise, overall subjective response to night vision was improved.

Even with these excellent overall outcomes, postoperative visual acuity cannot be guaranteed for any particular patient. The ultimate success of a refractive procedure often depends on the patient's expectations.

Loss of Vision:

In a patient deemed to be a good candidate, the risk of a complication after primary iLASIK or ASA that would require a corneal transplant is on the order of 1 in 10,000 to 1 in 50,000. Likewise, while it is possible for eyes to lose lines of best-corrected visual acuity (vision with glasses or contacts may not be as sharp as it was before the procedure) after refractive surgery, the FDA clinical trials for the Visx® Star S4 showed no eyes losing more than 2 lines of BCVA in any of the approved ranges for CustomVue™ treatment.

Over/Under Correction:

Since we treat all eligible patients with wavefront-guided CustomVue™ treatments, our overall rate of over- and under-correction is low. Nevertheless, if a patient has residual refractive error, an enhancement surgery can be performed as early as 3 to 6 months after their initial surgery. In patients with high preoperative refractive error, or those patients undergoing ASA, enhancement may be delayed to 6 or 12 months to ensure refractive stability. As for all procedures at HESLC, an individualized approach will be taken for all patients.

Visual Fluctuation:

Patients may experience visual fluctuation for several weeks or months after the refractive procedure. Because many patients are expecting instant "perfect vision" following refractive surgery, it is important to have a thorough discussion of the expected timing of visual recovery prior to their procedure. The severity and duration of their symptoms will depend on:

- Procedure performed (iLASIK or ASA)
- Type of refractive error (myopia, hyperopia, astigmatism, presbyopia)
- Degree of refractive correction (For iLASIK and ASA, the greater the treatment, the longer the healing)
- Individualized patient wound healing response

Presbyopia:

All presbyopic patients should understand how their refractive surgery procedures will (or will not) affect their near vision. Many pre- and early presbyopes will experience a transient period of increased presbyopic symptoms the first several weeks after refractive surgery. This typically resolves within the first couple of months.

Night Vision Symptoms:

Patients may experience night vision symptoms such as starbursts, glare, and halos around lights. These symptoms typically decrease dramatically over the first several weeks, although sometimes symptoms last for several months. Persistent night vision symptoms are more likely in patients with higher degrees of preoperative refractive errors. Frequently, there is residual postoperative refractive error which can be improved with nighttime driving glasses or enhancement surgery.

Dryness:

Up to 1/4th of patients may experience dry eyes after iLASIK and ASA. During this temporary period of dry eyes, frequent use of artificial tears is recommended. We regularly prescribe Restasis (cyclosporine A 0.05%) to increase tear production in the pre- and post-operative period. Punctal plugs may also be placed to relieve severe epithelial keratitis.

Ectasia:

This rare long-term complication results in irregular astigmatism which may require glasses or contact lenses to correct. Corneal thickness and preoperative signs of keratoconus are carefully screened in order to prevent the occurrence of ectasia.

Complications: iLASIK

Flap-related Complications

These complications after iLASIK rarely result in vision loss, and typically occur in only in about 1-2% of cases.

- **Diffuse Lamellar Keratitis:** DLK is a sterile interface inflammation which begins peripherally and later migrates centrally. Permanent visual loss from flap melting may occur if not diagnosed and treated in a timely fashion. Since DLK almost always presents by the first postoperative day, its occurrence will be noted and treated at HESLC. Steroids are the first line of treatment and rarely, flap lifting and irrigation is needed.
- **Macro/Microstriae:** Macrostriae are rare, and they typically result from flap dislocation prior to epithelial healing; immediate flap repositioning is indicated and curative. Microstriae are rarely visually significant, but can cause night vision symptoms and decrease visual acuity. Flap lifting, stretching, and repositioning within the first several weeks usually resolves the problem.
- **Epithelial Ingrowth:** Surface epithelial cells can grow into the flap interface. Typically having a light hazy sheet-like appearance with a scalloped leading edge, these cells can take on a gray pearl-like appearance when severe. Epithelial ingrowth can usually be seen between week 1 and month 1. More common after flap-lift enhancements, these cells may result in decreased vision, glare/halos, or foreign body sensation. All epithelial ingrowth should be monitored, and ingrowth more than 1 mm should be referred back to HESLC for evaluation. If left untreated, epithelial ingrowth may result in flap melting, scarring, irregular astigmatism, and loss of vision.

Infection

The rare but potentially visual threatening complication of infection should be considered in all cases of infiltrates after iLASIK. Prompt identification and initiation of treatment is critical to obtain an optimal outcome. Any infiltrate that has focal components and any infiltrate that does not follow the standard DLK time course (i.e. any infiltrate that first appears after postoperative day 1) should be treated as an infection. Fourth generation fluoroquinolones and fortified antibiotics should be applied on a very frequent basis. All corneal infiltrates should be referred back to HESLC

Complications: Advanced Surface Ablation (ASA)

Wound Healing

Most complications of ASA are related to epithelial wound-healing in the early postoperative period.

- **Persistent Epithelial Defect:** Since epithelial wound-healing problems are most often related to dry eyes, the surgeon typically inserts collagen punctal plugs at the time of surgery. Bandage contact lenses are also used to promote epithelial wound healing and to improve patient comfort. Aggressive lubrication with preservative-free ATs is prescribed. Occasionally, excessive or incorrect use of preserved drops can cause a toxic epitheliopathy as well.
- **Corneal Infiltrates:** Infiltrates can be sterile or infectious. Sterile corneal infiltrates are usually small, peripheral, and variably symptomatic with an intact epithelium. Causes include non-steroidal use or a tight-fitting contact lens. Infectious infiltrates are usually symptomatic (pain/photophobia), more central, and associated with conjunctival or anterior chamber reaction. Corneal melts and permanent visual loss may ensue, so aggressive management should be initiated as soon as possible. All corneal infiltrates should be referred back to HESLC.

Delayed Visual Recovery

Most patients usually recover driving vision within several days to one week after ASA. However, those with slow epithelial wound healing may have delayed visual recovery. Aggressive lubrication with punctal plugs will bolster the tear film and facilitate improved vision. For those with exceptionally slow recovery, a temporary spherical equivalent high DK contact lens fitting can result in improved visual function until the uncorrected vision is improved. Due to the delicate nature of the new epithelium, the lens is placed and removed weekly in the office.

It typically takes approximately 2 months for ASA patients' vision to stabilize. Prior to that time with-the-rule astigmatism may be found.

Corneal Haze

Corneal haze and scarring have been virtually eliminated with the use of new smoother ablation profiles. The anti-metabolite mitomycin C can also be used to treat old corneal haze or to prevent its development. Occasionally, trace subepithelial reticulated haze can be seen, but this is usually transient and improves after the first couple of months.

Steroid Response

Due to smooth ablation profiles the need for postoperative steroids is significantly less than what has been previously required. An IOP check at the one month postoperative visit (when the epithelium becomes stable) can screen for this complication.

Complications: Conductive Keratoplasty

Regression

The effect of all corneal procedures designed to correct presbyopia will change with time as the patient's accommodative amplitude continues to decline. If a patient is undercorrected or if there is unusual regression after CK, "bonus spots" can typically be placed to enhance the refractive effect.

Complications: Phakic Intraocular Lens or Clear Lensectomy

General

The rate of major sight-threatening complications from intraocular surgery is about 1 in 1000. Many of these potential complications are due to infections - this is why postoperative antibiotics and initial follow-up at HESLC are important.

Corneal Edema

Surgical manipulation in the anterior chamber can cause irritation to the corneal endothelium, occasionally resulting in transient corneal edema. This typically resolves within the first week, except in patients with Fuchs corneal endothelial dystrophy. Therefore, careful screening for corneal guttata is done preoperatively.

Cystoid Macular Edema

Postoperative inflammation may result in cystoid macular edema. Although usually not clinically significant, CME could cause visual loss, particularly in susceptible patients like diabetics. Postoperative steroids and nonsteroidal anti-inflammatory agents are routinely used in combination to prevent the occurrence of CME.

Posterior Capsule Opacification

Opacification of the posterior capsule (after lensectomy) is typically a late finding that can easily be treated with YAG laser capsulotomy no sooner than 3 months post-operatively.

Retinal Detachment

This rare complication is a particular concern in high myopes after lensectomy. Therefore, phakic intraocular lenses are the preferred approach to these patients. There is no apparent increase in the rate of RD after phakic IOLs.

Endophthalmitis

This rare and serious complication typically presents with severe decreased vision and pain; there is frequently a hypopyon and vitreous cells. Any concern for endophthalmitis should be referred back to HESLC immediately.

Refractive Surgery: Postoperative Medication

iLASIK

- **Zymar:** Use 1 drop, 4 times a day for 1 week.
- **Pred Forte:** Use 1 drop, 4 times a day for 1 week.
- **Artificial Tears:** Use preservative-free ATs up to every hour for the first month. At that point, traditional OR preservative free ATs can be used up to every hour.
- **Restasis:** If prescribed preoperatively, this can be restarted after the first week (when Zymar and Pred Forte are completed).

ASA

- **Zymar:** Use 1 drop, 4 times a day for 1 week.
- **Pred Forte:** Use 1 drop, 4 times a day for 1 week, 3 times a day for 1 week, 2 times a day for 1 week, 1 time a day for a week, then stop.
- **Comfort Drops** (Refresh, NSAID, and proparacaine): Use 1 drop, up to 6 times a day, ONLY if needed and only for the first week.
- **Vicodin:** Take one every 4-6 hours, as needed for pain.
- **Artificial Tears:** Use preservative-free ATs up to every hour for the first month. At that point, traditional OR preservative free ATs can be used up to every hour.
- **Restasis:** If prescribed preoperatively, this can be restarted after Pred Forte is completed.

Conductive Keratoplasty

- **Zymar:** Use 1 drop, 4 times a day for 1 week.
- **Acular LS (Acuvail or Nevanac):** Use 1 drop, 4 times a day for 1 week.
- **Comfort Drops** (Refresh, NSAID, and proparacaine): Use 1 drop, up to 6 times a day, ONLY if needed and only for the first week.
- **Artificial Tears:** Up to every 1 hour, as needed

Phakic Intraocular Lens or Clear Lensectomy

- **Zymar:** Use 1 drop, 4 times a day for 1 week, starting three days before the procedure.
- **Pred Forte:** Use 1 drop, 4 times a day for 2 weeks, 2 times a day for 2 weeks, 1 time a day for 2 weeks, then stop.
- **Acular LS (Acuvail or Nevanac):** Use 1 drop, 2 times a day for 2 weeks, starting three days before the procedure.

LRI (Limbal Relaxing Incision)

- Same treatment protocol as iLASIK.

Refractive Surgery: Postoperative Care Follow-up Schedule

All patients will be seen at HESLC on the first postoperative day. Typical postoperative visit schedules are presented below. Occasionally, additional visits may be required. If this is the case, all visits should be included in your comanagement fee. **Your comanagement fee does not include the cost of spectacles or contact lenses. You may choose to provide glasses to your patient at your own discretion.**

After completing each postoperative examination, we ask you to fax the exam form to Horizon Eye Specialists & Lasik Center at 480-419-5401. Proper follow-up and feedback will help us optimize our nomograms and ensure optimal results for your future patients.

UCVA: uncorrected visual acuity (note: always check distance and near UCVA)

MRx: manifest refraction

IOP: intraocular pressure

SLE: slit lamp exam

DFE: dilated fundus exam

***CRx:** cycloplegic refraction (only if enhancement on a non-presbyopic patient is being considered)

iLASIK and LRI

Day 1: UCVA, SLE (Performed at HESLC)

Week 1: UCVA, MRx, SLE

Month 1: UCVA, MRx, SLE, IOP

Month 3: UCVA, MRx, SLE, IOP, CRx*

Month 6 and 12: UCVA, MRx, SLE, IOP, CRx*, DFE

ASA

Day 1: UCVA, SLE (Performed at HESLC)

Week 1: UCVA, SLE, CTL removal (Performed at HESLC)

Week 2: UCVA, SLE

Month 1: UCVA, MRx, SLE, IOP

Month 3: UCVA, MRx, SLE, IOP, CRx*

Month 6 and 12: UCVA, MRx, SLE, IOP, CRx*, DFE

Conductive Keratoplasty

(Check monocular as well as binocular distance and near vision)

Day 1: UCVA, SLE (Performed at HESLC)

Week 1: UCVA, SLE

Month 1: UCVA, MRx, SLE, IOP

Month 3: UCVA, MRx, SLE, IOP, CRx*

Month 6 and 12: UCVA, MRx, SLE, IOP, CRx*, DFE

Phakic Intraocular Lens or Clear Lensectomy

Day 1: UCVA, SLE, IOP (Performed at HESLC)

Week 1: UCVA, SLE, IOP

Month 1: UCVA, MRx, SLE, IOP

Month 3: UCVA, MRx, SLE, IOP, CRx* (Phakic IOL only)

Month 6 and 12: UCVA, MRx, SLE, IOP, CRx* (Phakic IOL only), DFE

Note: the patient will be returned for co-management on a case by case basis, typically within 1 week to 1 month depending on the surgery and the initial result.

Post-op Care: iLASIK

Day 1 -

Symptoms: The patient should be comfortable. Mild foreign body sensation and dryness are common.

Vision may fluctuate mildly, but should be good.

Visual Acuity: Uncorrected vision is typically 20/40 or better, frequently 20/20 or better - if worse than 20/30, a manifest refraction is performed. Best-corrected visual acuity may be slightly reduced at this point.

Biomicroscopy: A clear flap w/faint well-aligned edges is expected. Trace interface opacities and flap edema can sometimes be seen. Any intra-lamellar inflammation is noted and treated. Occasional trace microstriae may be present, especially after large corrections, but these should be assessed for visual significance. Subconjunctival hemorrhages are normal.

Management: Routine postoperative drops are continued. Artificial tear use is encouraged. Slipped flaps with macrostriae should be repositioned immediately. Diffuse lamellar keratitis (DLK) should be treated and followed closely.

Week 1 –

Symptoms: Dryness with mild visual fluctuation that improves with lubrication is common.

Visual Acuity: Uncorrected vision is typically 20/25 or better - if worse than 20/30, a manifest refraction is performed. Best corrected visual acuity is usually recovered at this point. Night vision symptoms are not uncommon.

Biomicroscopy: A clear flap w/barely visible edges is expected. Interface opacities and microstriae should be unchanged from before. No inflammation or infiltrate should be present.

Management: Routine postoperative drops are discontinued. Artificial tear use is encouraged.

Month 1 –

Symptoms: Dryness with mild visual fluctuation that improves with lubrication is common.

Visual Acuity: Typically 20/25 or better. A manifest refraction is performed.

Biomicroscopy: A clear flap w/barely visible edges is expected. Interface opacities and microstriae should be unchanged from before. IOP can be checked by contact methods. A careful exam for epithelial ingrowth should be done.

Management: Artificial tear use is encouraged. Epithelial ingrowth should be referred back to HESLC.

Months 3-12 –

Symptoms: Dryness should be improved. Visual fluctuation should be less.

Visual Acuity: Typically 20/25 or better. A manifest refraction is performed and if the patient has a stable residual refractive error, an enhancement may be considered. Night vision should be significantly improved.

Biomicroscopy: A clear flap w/barely visible edges is expected. Epithelial ingrowth should be identified.

Management: Artificial tear use is encouraged. Patients considering enhancements should be referred back to HESLC.

After completing each postoperative examination, please fax the exam form to Horizon Eye Specialists & LASIK Center at 480-419-5401.

Post-op Care: ASA (Advanced Surface Ablation)

Day 1 -

Symptoms: The patient should be mildly uncomfortable. Foreign body sensation, scratchiness, and vision fluctuation are common. Discomfort should be relieved by topical and oral medications

Visual Acuity: Uncorrected vision is typically 20/40 to 20/100, although it can occasionally be better than 20/40. A manifest refraction would be difficult to perform and best-corrected visual acuity is limited at this point.

Biomicroscopy: A large epithelial defect with advancing margins is normal. The contact lens should fit well. Occasional trace corneal edema may be present. Subconjunctival hemorrhages are normal.

Management: Routine postoperative drops are continued. Artificial tear use is encouraged. Any infiltrate should be managed aggressively.

Week 1 -

Symptoms: Dryness with moderate visual fluctuation and the sensation of wearing an old contact lens is common.

Visual Acuity: Uncorrected vision is typically in the 20/30 to 20/40 range, although vision can range from 20/20 to 20/80.

Biomicroscopy: The epithelial defect should be closed with a central healing line. Epithelial irregularity can be seen and correlated with the visual acuity.

Management: The contact lens is removed. Routine postoperative drops are continued. Artificial tear use is encouraged. UV protecting sunglasses are recommended.

Month 1 –

Symptoms: Dryness with mild visual fluctuation that improves with lubrication is common.

Visual Acuity: Typically 20/25 or better. A manifest refraction is performed.

Biomicroscopy: Smooth epithelium with trace to no anterior stromal haze is expected. Punctate epithelial keratopathy can be seen in dry eyes. IOP can be checked by contact methods.

Management: Artificial tear use is encouraged. The steroid taper is completed.

Months 3-12 –

Symptoms: Dryness should be improved. Visual fluctuation should be less.

Visual Acuity: Typically 20/25 or better. A manifest refraction is performed and if the patient has a stable residual refractive error, an enhancement may be considered after at least 6 months. Night vision should be significantly improved.

Biomicroscopy: A clear cornea with decreasing anterior stromal haze is expected.

Management: Artificial tear use is encouraged. Patients considering enhancements should be referred back to HESLC.

After completing each postoperative examination, please fax the exam form to Horizon Eye Specialists & LASIK Center at 480-419-5401.

Post-op Care: Conductive Keratoplasty

Day 1 -

Symptoms: The patient should be comfortable. Mild foreign body sensation is common. Vision may fluctuate mildly, but should be good.

Visual Acuity: Uncorrected monocular near vision is typically J5 or better. Binocular near and distance vision should remain good.

Biomicroscopy: Eight (or more) CK-spots are seen in the peripheral cornea. Each spot may have overlying epithelial irregularity. Trace striae may be present between spots.

Management: Routine postoperative drops are continued. The patient is encouraged to use both eyes for all visual activities.

Week 1 –

Symptoms: The eye should be comfortable. Occasional foreign body sensation is not unusual.

Visual Acuity: Uncorrected monocular near vision is typically J2 or better. Binocular near and distance vision should remain good.

Biomicroscopy: The epithelium should be healed over the CK-spots. Striae should be diminished.

Management: Routine postoperative drops are discontinued. The patient is encouraged to use both eyes for all visual activities.

Month 1

Symptoms: The eye should be comfortable.

Visual Acuity: Near vision typically J2 or better. A manifest refraction is performed.

Biomicroscopy: CK-spots with smooth overlying epithelium should be present.

Management: The patient is encouraged to use both eyes for all visual activities.

Months 3-12

Symptoms: The eye should be comfortable.

Visual Acuity: Near vision typically J2 or better. A manifest refraction is performed.

Biomicroscopy: CK-spots with smooth overlying epithelium should be present.

Management: Patients considering enhancements should be referred back to HESLC.

After completing each postoperative examination, please fax the exam form to Horizon Eye Specialists & LASIK Center at 480-419-5401.

Post-op Care: Phakic Intraocular Lens or Clear Lensectomy

Day 1

Symptoms: The patient should be comfortable. Mild foreign body sensation and vision fluctuation are common. Vision is typically good.

Visual Acuity: Uncorrected vision is typically 20/40 or better.

Biomicroscopy: Occasional mild corneal edema may be present. Anterior chamber reaction is minimal. The intraocular lens should be well centered and in good position. The wound should be Seidel negative.

Management: Routine postoperative drops are continued and the patient is advised not to rub the eye. In clear lensectomy, self-sealing no-stitch wounds are typically used, while traditional stitches might be used with phakic IOLs.

Week 1

Symptoms: The eye should be comfortable. Occasional foreign body sensation is normal.

Visual Acuity: Uncorrected vision is typically 20/30 or better.

Biomicroscopy: The cornea should be clear. The anterior chamber should have only trace inflammation. The intraocular lens should be in good position.

Management: Routine postoperative drops are tapered.

Month 1

Symptoms: The eye should be comfortable.

Visual Acuity: Typically 20/25 or better. A manifest refraction is performed.

Biomicroscopy: The eye should be white and quiet with a well-positioned intraocular lens. Any stitches used with phakic IOLs may be removed.

Management: Reading or night-driving glasses are prescribed.

Months 3-12

Symptoms: The eye should be comfortable.

Visual Acuity: Typically 20/25 or better. A manifest refraction is performed and if the patient has a stable residual refractive error, an enhancement may be considered after at least 3 months.

Biomicroscopy: The eye should be white and quiet with a well-positioned intraocular lens.

Management: Patients considering enhancements should be referred back to HESLC.

Note: Patients undergoing Phakic IOL or Clear Lensectomy may require additional treatment if initial goals aren't achieved or if residual refractive error is expected (i.e. patients with severe astigmatism pre-operatively). iLASIK, ASA, LRI or any other necessary secondary procedure can be performed 2-3 months later once the refraction has stabilized.

After completing each postoperative examination, please fax the exam form to Horizon Eye Specialists & LASIK Center at 480-419-5401.

Refractive Surgery: Enhancements

Enhancements are an important component of the refractive surgical care that we provide at HESLC. Regardless of the initial procedure (LASIK, ASA, or lens implant), the initially achieved result can be adjusted with enhancement surgery. All efforts are made to achieve the desired results after a single surgery but if the desired refractive outcome is not achieved, if regression has occurred, or if the refractive goals need to be titrated (e.g. in monovision), enhancement surgery may be needed.

When to Enhance

Several factors are considered when determining whether a patient is an enhancement candidate. Prior to surgery, a thorough discussion of expectations and visual goals is undertaken to prepare the patient for reasonable postoperative expectations. Additionally, monovision patients undergo a contact lens trial prior to surgery. After surgery, enough time must be given for refractive stability to be achieved, which again depends on the procedure involved and the initial refractive error. Typically, at least 3-6 months are needed after myopic LASIK, and 6-12 months are needed after hyperopic LASIK. Similarly, ASA patients can have continued improvement in their vision for up to 6-12 months after surgery, so enhancements should not be considered until that time.

Criteria

Assuming that the patient has achieved refractive stability, the following are guidelines for considering enhancement surgery:

1. Patient's (reasonable) goals not met
2. Uncorrected visual acuity < 20/40
3. Significant symptomatic anisometropia

A consult for an enhancement will be similar to the initial refractive consultation. The same extensive preoperative measurements are performed (including wavefront analysis), with an emphasis on refractive stability. The patient meets with the surgeon, and a refractive plan is created. If an enhancement surgery is needed, the same treatment and care will be provided as during the initial procedure. For excimer laser procedures, wavefront-guided treatments are performed for all applicable cases.

Cataract Surgery: Lens Options

At HESLC, cataracts continue to be removed via phacoemulsification using a no-stitch technique. In this procedure, high-energy ultrasound waves are used to gently remove the cataract. In most cases we use only eye drop anesthesia, allowing our patients the fastest possible recovery. The most significant change in recent years has been the introduction of custom cataract surgery with premium intraocular lens options.

Monofocal IOLs

The traditional intraocular lens offering very good near or distance vision for everyday activities. However, most people receiving these lenses still require reading glasses or bifocals to have a full range of vision. For patients with less than optimal potential visual acuity (i.e. secondary to moderate to severe ARMD) this type of lens is still the best option.

Premium IOLs

Tecnis®

Tecnis® is a multifocal intraocular lens combining an aspheric front surface with a fully diffractive back surface that, unlike a standard IOL, can correct distance, intermediate and near vision in all lighting conditions. With this lens, nearly 9 out of 10 patients do not require glasses. Furthermore, it's the lens 94% of patients would choose again.

Crystalens®

The only FDA approved accommodating intraocular lens, the Crystalens® HD is a "single focus" hinged aspheric IOL correcting distance, intermediate and near vision. Modeled after the natural lens, it uses the ciliary muscles to flex and accommodate in order to provide a full range of vision. With this lens, more than twice the number of patients could see well at all distances compared to a standard monofocal IOL.

ReSTOR®

The AcrySof® IQ ReSTOR® is an aspheric multifocal intraocular lens with an apodized diffractive central optic surrounded by an outer refractive ring or zone. This means the series of tiny steps in the center area work together to focus light for near through distance vision while the outer region is dedicated to focusing light for distance vision.

AcrySof® IQ Toric

This aspheric toric intraocular lens offers a range of cylinder powers for patients seeking spectacle-independent distance vision. Its single-piece platform ensures exceptional rotational stability, with < 4° average rotation 6 months after implantation. Most patients will still need corrective lenses for intermediate and near tasks.

Note: All of these lenses can be used in Clear Lensectomy.

Premium IOLs: Patient Selection

Note: with a time proven history of modern cataract surgery and co-management, this manual will only address patient selection as it pertains to premium intraocular lenses and not cataract surgery requirements in general.

Patient Selection

Much like refractive surgery, the key to a happy premium IOL cataract surgery patient begins with good patient selection. A patient's candidacy for premium IOLs involves not only eye-related objective findings (ocular health, potential visual acuity, etc.) but also non eye-related subjective factors (patient goals and expectations). Once again, you are uniquely positioned to provide the best insight as to the candidacy for a these types of lenses.

Patients are most likely to be happy with the results of their surgery if they have a specific and realistic objective in mind. Patients with unrealistic demands such as "perfect vision" or total spectacle independence will probably not be satisfied until perfection is achieved. Patients without a specific occupational, sports, or hobby related objective, must be carefully educated about the limitations of premium IOLs so their expectations are reasonable.

For a more detailed discussion regarding appropriate patient selection, refer once again to page 6.

Cataract Surgery: Preoperative Care

Similar to refractive surgery preoperative care (starting on page 7), a thorough review of medical and ocular history is performed in addition to an extensive eye exam. Some key points for the co-managing optometrist:

IOL Calculation

Stable keratometric findings are crucial for IOL calculations. Like refractive surgery patients, remember these simple contact lens guidelines.

- **Soft contact lenses** should be removed **at least 3 days** prior to testing.
- **Toric lenses** should be removed **at least 1 week** prior to testing.
- **Hard or RGP lenses** should be removed at least **3 weeks** (or longer) prior to testing.

If any change or distortion is noted, it will be necessary to leave the lenses out for a longer period of time until the refraction and/or topography show stabilization.

Potential Visual Acuity

Some patients may not realize they have more than one ocular health condition affecting their vision and think cataract surgery alone will solve their problem. The patient's vision potential must be established and the findings discussed in detail prior to surgery to keep expectations realistic. Furthermore, these conditions (i.e. moderate to severe ARMD, amblyopia, corneal scarring, etc.) may preclude them from having a premium IOL inserted.

Cataract Surgery: Risks and Complications

General

The rate of major sight-threatening complications from intraocular surgery is about 1 in 1000. Many of these potential complications are due to infections - this is why postoperative antibiotics and initial follow-up at HESLC are important.

Corneal Edema

Any corneal edema found typically resolves within the first week, except in patients with Fuchs endothelial dystrophy. Therefore, careful screening for corneal guttata is done preoperatively.

Cystoid Macular Edema

Postoperative inflammation may result in cystoid macular edema which can cause visual loss, particularly in susceptible patients like diabetics. Postoperative steroids and nonsteroidal anti-inflammatory agents are routinely used in combination to prevent the occurrence of CME.

Posterior Capsule Opacification

Opacification of the posterior capsule is typically a late finding that can easily be treated with YAG laser capsulotomy no sooner than 3 months post-operatively.

Retinal Detachment

This is a rare complication, but of greater concern for high myopes after cataract surgery.

Endophthalmitis

This rare and serious complication typically presents with severe decreased vision and pain; there is frequently a hypopyon and vitreous cells. Any concern for endophthalmitis should be referred back to HESLC immediately.

Premium IOLs:

Glare and/or Halos

It should be noted all lenses, including traditional monofocal lenses, may cause some degree of halos and glare around light sources at night. When considering premium IOLs, an accommodating lens implant like the Crystalens® generally has less risk of halos and glare than a multifocal lens like Technis®. However, these distortions rarely prevent night driving and, through the process of neural adaptation, most people learn to ignore them over time.

Spectacle Correction

Just like refractive surgery, total spectacle independence is never guaranteed. Although the majority of patients perform their daily tasks without glasses, some may feel they prefer or need glasses for specific activities.

Enhancements

Premium (or monofocal) IOL patients may require additional treatment if initial goals aren't achieved or if residual refractive error is expected (i.e. patients with severe astigmatism pre-operatively). iLASIK, ASA, LRI or any other necessary secondary procedure can be performed 2-3 months later once the refraction has stabilized.

Cataract Surgery: Postoperative Medication

- **Zymar:** Use 1 drop, 4 times a day for 1 week, starting three days before the procedure.
- **Pred Forte:** Use 1 drop, 4 times a day for 2 weeks, 2 times a day for 2 weeks, 1 time a day for 2 weeks, then stop.
- **Acular LS (Acuvail or Nevanac):** Use 1 drop, 2 times a day for 2 weeks, starting three days before the procedure.

Cataract Surgery: Postoperative Care Follow-up Schedule

All patients will be seen at HESLC on the first postoperative day. A typical postoperative visit schedule is presented below. Occasionally, additional visits may be required. If this is the case, all visits should be included in your comanagement fee. ***Your comanagement fee does not include the cost of spectacles or contact lenses. You may choose to provide glasses to your patient at your own discretion.***

After completing each postoperative examination, we ask you to fax the exam form to Horizon Eye Specialists & Lasik Center at 480-419-5445. Proper follow-up and feedback will help us ensure optimal results for your future patients.

UCVA: uncorrected visual acuity (note: always check distance and near UCVA)

MRx: manifest refraction

IOP: intraocular pressure

SLE: slit lamp exam

DFE: dilated fundus exam

Starting with Day 1 for unilateral surgery or following the second eye of bilateral surgery –

Day 1: UCVA, SLE, IOP (Performed at HESLC)

Week 1: UCVA, SLE, IOP

Month 1: UCVA, MRx, SLE, IOP

Month 3, 6 and 12, if applicable: UCVA, MRx, SLE, IOP, DFE

Note: the patient will be returned for co-management on a case by case basis, typically within 1 week to 1 month depending on the IOL used and the initial result.

Post-op Care: Cataract Surgery

Day 1

Symptoms: The patient should be comfortable. Mild foreign body sensation and vision fluctuation are common. Vision is typically good.

Visual Acuity: Uncorrected distance vision is typically 20/40 or better. With a premium IOL, uncorrected near vision is typically J3 or better.

Biomicroscopy: Occasional mild corneal edema may be present. Anterior chamber reaction is minimal. The intraocular lens should be well centered and in good position. The wound should be Seidel negative.

Management: Routine postoperative drops are continued.

Week 1

Symptoms: The eye should be comfortable. Occasional foreign body sensation is normal.

Visual Acuity: Uncorrected distance vision is typically 20/30 or better. With a premium IOL, uncorrected near vision is typically J3 or better. A manifest refraction is performed when applicable.

Biomicroscopy: The cornea should be clear. The anterior chamber should have only trace inflammation. The intraocular lens should be in good position.

Management: Routine postoperative drops are tapered.

Month 1

Symptoms: The eye should be comfortable.

Visual Acuity: Uncorrected distance vision is typically 20/25 or better. With a premium IOL, uncorrected near vision is typically J2 or better. A manifest refraction is performed.

Biomicroscopy: The eye should be white and quiet with a well-positioned intraocular lens.

Management: For monofocal IOL patients or content premium IOL patients, reading or night-driving glasses can now be prescribed.

Months 3-12

Symptoms: The eye should be comfortable.

Visual Acuity: Typically 20/25 or better. A manifest refraction is performed and if the patient has a stable residual refractive error, an enhancement may be considered after at least 3 months.

Biomicroscopy: The eye should be white and quiet with a well-positioned intraocular lens.

Management: Patients considering enhancements should be referred back to HESLC.

Note: Premium (or monofocal) IOL patients may require additional treatment if initial goals aren't achieved or if residual refractive error is expected (i.e. patients with severe astigmatism pre-operatively). iLASIK, ASA, LRI or any other necessary secondary procedure can be performed 2-3 months later once the refraction has stabilized.

After completing each postoperative examination, please fax the exam form to Horizon Eye Specialists & Lasik Center at 480-419-5401.

Our Surgeons

Robert R. McCulloch, M.D.



Dr. Robert R. McCulloch is a Diplomate of the American Board of Ophthalmology and the Senior Cataract Surgeon with Paradise Valley Eye Specialists, having performed more than 12,000 cataract, glaucoma and corneal transplant procedures. As a specialist in refractive surgery, he also serves as Medical Director and Senior Refractive Surgeon for Horizon Eye Specialists & Lasik Center.

Dr. McCulloch is a Magna Cum Laude graduate of Creighton University School of Medicine in Omaha, Nebraska where he was elected to the Alpha Omega Alpha Medical Honor Society. After serving an internship at Creighton, Dr. McCulloch completed an Ophthalmology Residency at Baylor College of Medicine in Houston, Texas. He also completed a Fellowship in corneal and external disease at Baylor College of Medicine.

Dr. McCulloch is an active member in several medical societies including the American Medical Association, the Association for Research, Vision in Ophthalmology and the Association of Microbiology and Immunology Group.

Harmohina Bagga, M.D.



Dr. Bagga is a fellowship trained glaucoma surgeon. With her extraordinary training and experience, we expect that Dr. Bagga will become one of the most sought-after glaucoma specialists in Arizona. She was a research fellow at the Bascom Palmer Eye Institute in Miami where she spent three years studying improved methods for both diagnosing and treating glaucoma. She served three years in the Department of Ophthalmology at the Northwestern University School of Medicine in Chicago. Most recently, she has served as a fellow at the Shiley Glaucoma Center at the University of California at San Diego.

In addition to remarkable level of experience and skill, her associates describe Dr. Bagga as an extremely warm and caring physician who quickly endears herself to her patients.

She is a member of the American Glaucoma Society, the Association for Research in Vision and Ophthalmology and the American Academy of Ophthalmology.

Dr. Bagga will be caring for both glaucoma and cataract patients at all of our offices.