June 26, 2024

Members of the Nevada Board of Optometry,

We are writing to address the Optometry scope of practice concerning the treatment of the whole face with IPL, Radiofrequency, and Low Level Light Therapy.

Esteemed experts in the field, including Dr. Laura Periman, Dr. Rolando Toyos, Dr. Art Epstein, Dr. Douglas Devries, Dr. Selina McGee, Dr. Cory Lappin, and Dr. Bruce Dornn, have conducted extensive research on dry eye disease, meibomian gland dysfunction, and rosacea. Dr. Toyos identifies these conditions as involving both the skin and glands. Focusing solely on the eyes without considering the broader facial context may limit our ability to provide optimal patient care.

It is crucial to recognize that the facial vascular plexus plays a significant role in the health of the eyelids. Neglecting treatment of this interconnected network could compromise treatment efficacy. For instance, IPL targets facial blood vessels that release inflammatory mediators known to contribute to conditions like dry eye disease and meibomian gland dysfunction. Studies indicate that treating both the eyelids and adjacent facial areas reduces levels of these mediators more effectively than eyelid treatment alone.

Furthermore, FDA trials for the treatment of dry eye disease related to meibomian gland dysfunction with IPL include areas beyond the immediate eyelid region. Deviating from these established protocols risks diminishing treatment effectiveness. The Lumenis device was granted FDA approval for the treatment of dry eye disease in 2021.

Experts in our field have developed carefully considered protocols for addressing ocular conditions such as dry eye disease, meibomian gland dysfunction, ocular rosacea, and chalazion treatment. These protocols commonly involve treating areas that extend beyond the immediate eyelid, including the forehead, midface, and face itself.

In contrast, current regulations in Nevada permit advanced aestheticians, with significantly less training of 900 hours, to perform IPL, Radiofrequency, Low Level Light Therapy, Ultrasonic techniques, Nanoneedling, Microchanneling, Laser Hair Removal and other treatments with minimal oversight (signed collaboration document) by a healthcare professional. As Optometrists, with extensive education and training spanning over eight years, we believe we are uniquely qualified to provide both medical and aesthetic treatments for the eyelids and face.

We believe it is essential for Optometrists to lead in comprehensive eye care, ensuring patients receive treatment from qualified healthcare providers rather than seeking alternative care options from an aesthetician. Granting Optometrists the ability to perform these treatments or even

consideration of collaboration with another healthcare provider such as MDs, RNs, or PAs would represent a progressive step forward for our profession.

We appreciate the Board's consideration of this matter and respectfully urge you to reconsider the scope of practice to include the face. This adjustment would enable us to better serve our patients and uphold the highest standards of care in Optometry.

Thank you for your time and thoughtful consideration.

Sincerely,

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Thomas Gall, OD

On behalf of the almost 40 Nevada optometrists that I have been in contact with that perform advanced dry eye procedures, I would like to thank the board for giving the application of these technologies more consideration. As the board seemed unfamiliar with the standard protocols used by optometrists across the nation, I'd like to review their use. The Toyos protocol used for IPL involves pulsing light from the tragus of one ear, across the cheeks, over the nose, and to the opposite tragus. This is the on label approach used in the FDA trials for the Optilight device, applying light energy to the skin of the face using a crystal 15x35mm wide. Since the last board meeting, I was able to speak with Dr. Toyos. In that conversation we discussed the development of his now standard protocol. Of particular note, he stated lid only application was found inferior compared to tragus to tragus and full face treatments. It is theorized that a minimum amount of light energy must be applied to the skin of the face around the eyes to adequately create the desired effect within the eye and lids. This is why the late Dr. Arthur Epstein promoted the use of IPL on the forehead of male patients in effort to increase the energy supplied as IPL should not be done over the beard follicles.

Radiofrequency is typically applied using a 20mm diameter wand in a C-shaped pattern along the orbital ridge. While there are published studies applying either IPL or radiofrequency to the lids directly, these protocols are not standard and present increased risk to the patient, requiring the placement of protective corneal shields during the procedures.

Low level light therapy is typically applied by either placing a mask over the face or by using a large panel of lights, 2-3 times the size of a sheet of paper, placed in front of the face.

I feel that the board may be placing an unnecessary restriction on these radiation therapies. As mischaracterized in the last meeting, no one is disputing the definition of ocular appendages. My argument is that Nevada's statutes do not specify that treatments may only be applied directly to the eye and its appendages. In NRS 636.025, subsection 1(c), optometrists are limited to the "examination, evaluation, diagnosis and treatment of the human eye and its appendages." The statute does not include language that specifies that treatment prescribed for the benefit of the eye and its appendages may only be applied locally to those tissues, only that the reason be limited to treating the eye and appendages. I would also suggest the statute appears to be written to accept advances in treatment as they arise so long as they are both employed in the effort to treat the eye and its appendages and do not violate the surgical restrictions placed on optometry. I hope the board can at least agree that the letter of the law in this case could be interpreted differently and suffers from some ambiguity. Of note, precedence has already been set that Nevada optometrists may treat the eye remotely and indirectly with the use of oral

pharmaceuticals, so applying treatment outside the eye and its appendages is not novel treatment for Nevada optometrists. At minimum, I think we can agree that IPL, radiofrequency and low level light therapies in no way cut, burn or vaporize human tissue when used as intended and as such do not fall under the prohibitive surgical treatments as described in 636.025 subsection 2(a). Should the board continue its stance on these technologies until legislative action can occur, I beg them to not limit the application to any specific anatomy such as tragus to tragus as protocols are constantly evolving and I fear we would repeat history with some new treatment variation.

As the standard treatment protocols for these procedures are typically performed on the face and not directly to the eyelids, I hope the board can see the conundrum they have placed Nevada optometrists in. Should we abide by the restrictions as stated previously by the board we are ignoring the standard of care by which these procedures are to be performed and subjecting Nevadans to less proven and riskier variations of treatment.