# *NEVADA STATE BOARD OF OPTOMETRY*

**MARIAH SMITH, O.D.**
**Board President**

**JULIE C. ALAMO-LEON, O.D.**
**Board Member**

**Post Office Box 1824**
**Carson City, Nevada 89702**
**Telephone: (775) 883-8367**
**Facsimile: (775) 305-0105**

**ADAM SCHNEIDER, ESQ.**
**Executive Director**

**JEFFREY AUSTIN, O.D.**
**Board Member**

**SALLY BALECHA**
**Public Board Member**

# Materials for Item No. 10 re

- Complaint 23-11

Inquiry letter (redacted);
Licensee narrative response (redacted);
Licensee table re medical chronology (redacted); and
Medical records 2017-2020, 2021, 2022, 2023, 2024 (redacted)

# *NEVADA STATE BOARD OF OPTOMETRY*

**MARIAH SMITH, O.D.**
**Board President**

**JULIE C. ALAMO-LEON, O.D.**
**Board Member**

**Post Office Box 1824**
**Carson City, Nevada 89702**
**Telephone: (775) 883-8367**
**Facsimile: (775) 305-0105**
**E-Mail: admin@nvoptometry.org**

**JEFFREY AUSTIN, O.D.**
**Board Member**

**SALLY BALECHA**
**Public Board Member**

**ADAM SCHNEIDER, ESQ.**
**Executive Director**

[Licensee address]

[Licensee email address]
*via email only*

Re: NSBO Complaint# 23-11
Patient: [Patient name]

Dear Dr. [Licensee]-

This office has received information and a complaint alleging your care and treatment of the above-referenced patient may have been unprofessional as defined in Nevada Revised Statute (NRS) 636.295 and Nevada Administrative Code (NAC) 636.230. It is alleged:

> [OMD practice] has treated me as a patient since 2017 because I have glaucoma in my left eye. I've been blind on my right side since I was very young. During this time, I've seen doctors [OMD1], [OMD2], and [Licensee]. However, I saw Dr. [Licensee] the most frequently. When [Licensee] saw me, I had uncontrolled eye pressure and an eye infection (from 11/2021-4/2022), and [Licensee] said it was an irritation. [Licensee] advised me to place a warm towel over my eye and prescribed an ointment for the irritation. Despite my repeated complaints about my eyesight deteriorating and my eye condition, [Licensee] did nothing to assist me in getting better.
>
> Since my eye infection was worsening and I needed medical attention immediately, I went to an urgent care facility to see a doctor. However, the urgent care doctor refused to treat me because I had conjunctivitis, and he was unable to prescribe me any more medication because I had glaucoma and was already taking several medications to manage my condition. He advised that I visit my glaucoma specialist right away. He suggested that I put a cold towel on my eye instead of a warm one. After making numerous attempts to request that I want to see a different doctor, my wife came to one of my doctor's appointments with Dr. [Licensee]. She demanded that I see another doctor because I was not getting assistance. [Licensee] became upset and said it wasn't necessary, but I knew that my medical condition was getting worse.

On April 7, 2022, I saw Dr. [OMD2]. After examining my eyes and going over my medical history, he concluded that my eye pressure was out of control and advised glaucoma surgery with trabeculectomy to save my vision. Dr. [OMD2] was unable to respond when I asked him why this surgery hadn't been performed earlier. I was worried about the surgery because I only saw with my left eye and was afraid of losing it and going blind. I, therefore, asked my primary physician to refer me to Dr. Joseph Caprioli at the UCLA Health Stein Eye Institute for a second opinion. I wanted to know if the surgery Dr. [OMD] recommended was the right one.

My appointment with Dr. Caprioli was on May 10, 2022. He performed tests, saw my medical records, and agreed with the trabeculectomy eye surgery that Dr. [OMD2] was recommending. If I didn't get the surgery, I would be at risk of being blind. But he questioned why they were just having the surgery; it needed to be done sooner. He compared the exams he did with the ones done in Las Vegas in January and said that I had lost too much vision between then and now. It should have been performed about two years ago. He also mentioned that the ointment Dr. [Licensee] had prescribed for my glaucoma was the incorrect one because it contained steroids.

Dr. [OMD2] performed the surgery on May 18, 2022, but because it wasn't scheduled sooner, my optic nerve was damaged, and now I have low vision, which is considered legally blind. Both my life and the lives of my family have changed as a result. I blame Dr. [Licensee] for [Licensee's] negligence and make [Licensee] responsible for my blindness. [Licensee] could have sent my case for review if [Licensee] noticed that my eye pressure and eye infections were worsening, but [Licensee] decided to keep prescribing medications that were not helping me. I thank Dr. [OMD2] for acting fast on my medical situation, even though I'm now blind.

Pursuant to NRS 636.305(3), in order to determine whether or not there has been a violation of NRS/NAC 636, please provide a written response to each allegation noted above, as well as a full and complete copy of your healthcare records, billing, invoices, and communications to and from the aforesaid patient. Please include any further information you believe would be useful for the Board to make a determination in this matter.

Your reply to director@nvoptometry.org is due **on or before end of business August 21, 2024**. Should the records be voluminous, usage of Dropbox or ShareFile or the like is encouraged.

Please return the healthcare records and billing with the signed Custodian of Records Declaration, enclosed herewith. If you are not the custodian of records, please indicate where the healthcare records can be obtained.

The Nevada State Board of Optometry investigates all information received concerning possible violations of NRS/NAC 636. This letter is not to be construed as a determination as to whether or not there has been a violation of such laws until a thorough investigation is completed. This correspondence is sent pursuant to NRS 636.305(2) and NRS 636.310(3), and the accompanying subpoena is sent pursuant to NRS 636.141. As a licensee subject to an investigation, you are required by law to provide the requested information.

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the law, specifically including but not limited to NRS 636.295(4) (gross incompetency), (8) (unprofessional conduct in the practice of optometry), (9) (any violation of NRS 636 or NAC 636) and NAC 636.230 (unprofessional conduct with the failure to comply with any provision of a federal, state or local law, ordinance or regulation relating to the provision of optometric services).

Respectfully,

*/s/ Adam Schneider*
Adam Schneider, Esq.
Executive Director

September 9, 2024

**VIA EMAIL to director@nvoptometry.org**

Adam Schneider, Esq.
Executive Director
Nevada State Board of Optometry
Post Office Box 1824
Carson City, NV 89702

Re: NSBO Complaint #23-11
Patient: [Patient name]

Dear Nevada State Board of Optometry:

Thank you for the opportunity to address Complaint #23-11 before the Nevada State Board of Optometry. I take the concerns raised by [Patient] very seriously and I appreciate the opportunity to share my thoughts on his care.

By way of background, I am an optometrist with residency training in ocular disease and glaucoma certification in Nevada. Since 2015, I have had the privilege of caring for patients at [practice location] alongside a skilled team of [OMDs].

**Patient Overview:**

[Patient], a 60-year-old male with a history of Primary Open Angle Glaucoma in his left eye (OS), has been under our care since November 2017. His right eye has been non-visual due to childhood strabismic amblyopia and extensive retinal damage. He also has multiple systemic health conditions, including hypertension, diabetes, a left posterior communicating artery stroke, a patent foramen ovale, and obstructive sleep apnea.

From April 2019 to March 2022, I provided ongoing care for [Patient]. Throughout this time, I regularly consulted with glaucoma specialist Dr. [OMD1] who personally examined the patient and fully supported my treatment decisions, which helped maintain his vision at 20/20 to 20/25. As glaucoma is a chronic and progressive disease that can sometimes worsen despite careful management, it became apparent towards the end of my care that surgical intervention was necessary as medical treatment was no longer effective. After consulting with Dr. [OMD1], we agreed that trabeculectomy surgery was necessary, and it was scheduled for May 18, 2022. [Patient] is now exclusively under Dr. [OMD1]'s care.

**Summary of Care (Left Eye):**

- **November 2017 - August 2018:** Under Dr. [OMD2]'s care, [Patient]'s vision remained stable at 20/20, with intraocular pressures (IOP) ranging from 8 to 19 mmHg. He was prescribed Latanoprost.
- **April 2019 - July 2019:** I assumed his care after a gap in visits, maintaining his stable vision at 20/20 with borderline IOPs (20-21 mmHg). The optic nerve showed a stable cup-to-disc (C/D) ratio of 0.8. I reinforced the importance of medication adherence and scheduled follow-up tests to closely monitor his condition.
- **November 2019:** During a follow-up with Dr. [OMD3], the patient reported severe pain. IOP was 16 mmHg with possible progression indicated by visual field testing. Despite stable vision, further tests were ordered, including an MRI, due to the patient's recent stroke.
- **January 2020:** I continued monitoring, noting stable vision and IOP at 16 mmHg. Visual field testing showed mild glaucoma with no progression. Maintaining ongoing care with the neurologist-ophthalmologist Dr. Aroucha Vickers due to the recent stroke.
- **August 2020:** Patient presented four months later than recommended. IOP spiked to 43 mmHg, necessitating immediate intervention. I instilled Rocklatan and Combigan in office to verify pressure-lowering efficacy. The patient was instructed to use Combigan twice a day (BID) OS, Rocklatan at bedtime (QHS) OS, and Dorzolamide BID OS. I arranged for the patient to return the following day to see glaucoma specialist Dr. [OMD1] for management of the elevated IOP and evaluation for possible surgery. One day later, direct consultation with Dr. [OMD1] confirmed that surgery was not needed at that time due to effective topical medication control. This careful collaboration and rapid response were key to managing the patient's elevated IOP.
- **September 2020 - April 2021:** I maintained consistent treatment, keeping IOP well-controlled between 9-13 mmHg, with no significant progression. Continued care with neurologist-ophthalmologist Dr. Vickers for headaches.
- **May - June 2021:** The patient developed a chalazion. I treated it with Maxitrol ointment and hot compresses, successfully resolving the issue without impacting his IOP.
- **July 2021 - January 2022:** I monitored recurring chalazion issues, adjusting treatment as needed. By January, I increased Dorzolamide from two times a day to three times a day due to possible visual field progression despite stable IOP at 16 mmHg.
- **March 2022:** The patient developed a possible allergic reaction to medication. IOP elevated to 27 mmHg. I adjusted the treatment plan by discontinuing Dorzolamide three times a day (TID) OS, continuing Combigan OS BID and Latanoprost OS QHS, and introducing Rhopressa QHS OS (which the patient had used in the past with success). Additionally, ophthalmic grade petroleum jelly was recommended for external eyelid irritation. I promptly referred the patient back to Dr. [OMD1] in one week to check IOP and explore surgical options. Visual acuity remained 20/25 during this last visit with the patient.

- **April 2022:** Dr. [OMD1] recommended a trabeculectomy based on the patient's condition. The surgery was scheduled for the next available date, May 18, 2022. The patient continues under Dr. [OMD1]'s exclusive care.

**Response to Specific Allegations:**

1. Eye Infection and Allegation of Incorrect Medication Prescription

On May 26, 2021, I diagnosed [Patient] with a chalazion, which presented as inflammation due to a blocked meibomian gland. I recommended hot compresses, preservative-free artificial tears, and Maxitrol ointment, a commonly prescribed antibiotic and steroid. Given [Patient]'s glaucoma, I was mindful of the potential risk of increased IOP from steroid use, and I closely monitored his eye pressure throughout. Once the chalazion resolved, I promptly discontinued the ointment. The Maxitrol ointment was prescribed specifically for the chalazion, not for glaucoma, and there were no adverse effects related to its use.

When the patient returned on March 30, 2022, reporting a rash around his eyes, I suspected an allergic reaction to his glaucoma medication. I adjusted his treatment by discontinuing Dorzolamide and reintroducing Rhopressa, which he had previously tolerated well. I also recommended petroleum jelly for external irritation. All decisions were made in line with standard clinical guidelines and the patient was referred back to glaucoma specialist Dr. [OMD1] for further management.

2. Uncontrolled Eye Pressure

[Patient]'s IOP was closely monitored at each visit, and adjustments were made in consultation with glaucoma specialist Dr. [OMD1]. In review of the patient's IOP history, his eye pressures were mostly controlled in the range of 12-16 mmHg for the vast majority of clinic visits. There were two major instances where increased IOP was noted, both of which may have been due to poor compliance or improper use of topical medications; these issues were promptly addressed.

For instance, on August 12, 2020, when his IOP was elevated, I promptly initiated emergency treatment with Dorzolamide BID OS, Combigan BID OS, and Rocklatan QHS OS, while informing Dr. [OMD1]. I arranged for him to be seen by Dr. [OMD1] within 24 hours, during which his pressures were successfully reduced to safe levels, preventing the immediate need for surgery.

In January 2022, I noticed possible progression in his visual field testing, even though his IOP was within target. In response, I increased his medication and scheduled an earlier follow-up for repeat testing to confirm visual field defects.

Lastly, on March 30, 2022, when his IOP was elevated with possible signs of an allergic reaction, I promptly discontinued the suspected medication Dorzolamide, and restarted

Rhopressa, a medication well-tolerated for him in the past. Given the potential need for surgical intervention, I referred him back to Dr. [OMD1] who recommended trabeculectomy surgery. Throughout, I ensured that any significant changes in his condition were managed with care and close collaboration with Dr. [OMD1].

3. Visit to Urgent Care and Recommendation for Immediate Specialist Review

I am not familiar with the details of [Patient]'s urgent care visit. While cold compresses can help reduce inflammation, they do not directly address the underlying cause of a chalazion, which may be better treated with warm compresses to promote gland drainage, as I had recommended. My prescribed treatment followed standard of care guidelines, and I referred him to Dr. [OMD1] for further evaluation.

Regarding specialist care, [Patient] was already under the care of glaucoma specialist Dr. [OMD1] at the time of his urgent care visit. Additionally, his glaucoma was regularly monitored by myself and he has seen at least three other ophthalmologists: Dr. [OMD2], Dr. [OMD3], and Dr. Vickers.

**Response to Additional Questions from the Director of the Board:**

1. Why wasn't MIGS or trabeculectomy considered earlier?

Minimally Invasive Glaucoma Surgery (MIGS) and trabeculectomy are typically considered when medication is no longer effective in controlling IOP. During my care, [Patient]'s IOP was successfully managed with medications ranging from 12-16 mmHg for the vast majority of visits, and his vision remained stable at 20/20 to 20/25. Given his complex medical history—including low vision in the right eye, hypertension, diabetes, stroke, and other conditions—we carefully considered the potential benefits and risks of surgery at every visit.

However there were two specific instances where surgery was strongly considered due to uncontrolled IOP. The first occurrence was on August 12, 2020, when [Patient] presented four months later than had been recommended with an elevated IOP of 43. I promptly initiated emergency topical treatment, had him wait in the clinic to make sure his pressure was responding, and arranged for him to be seen by glaucoma specialist Dr. [OMD1] within 24 hours. Dr. [OMD1] agreed with my assessment and plan, and since the pressures were brought under control with medications, surgical intervention was not necessary at that time.

The second occurrence of high IOP occurred during [Patient]'s visit on March 30, 2022. Despite being on multiple topical medications, his IOP remained elevated. At that point, I promptly referred him back to Dr. [OMD1], who agreed on his April 7, 2022 visit that surgical intervention was necessary as benefits outweighed potential risks.

The timing of surgical intervention was carefully evaluated in consultation with glaucoma specialist Dr. [OMD1]. Surgery was not pursued earlier, per Dr. [OMD1]'s personal

assessment, as the patient's condition did not warrant it, with the potential risks outweighing the benefits. In August 2020, when [Patient]'s IOP spiked, I promptly managed it with topical medications, successfully lowering his pressure to safe levels, which avoided the need for surgery at that time. However, during my final visit on March 30, 2022, despite adjustments to his medications, his IOP remained uncontrolled. I immediately referred him to Dr. [OMD1] for further evaluation, and Dr. [OMD1] concurred with my assessment, recommending trabeculectomy, as medical management was no longer sufficient to control his elevated IOP.

2. Why didn't an OMD evaluation occur any earlier than April 7, 2022, especially when the patient had glaucoma in his OS since 2017 and was low-vision in his OD since birth?

[Patient]'s care was a collaborative effort involving myself and at least four other eye specialists. His care was initiated by ophthalmologist Dr. [OMD2], who saw him regularly between November 2017 and August 2018. Additionally, [Patient] was also under the care of neuro-ophthalmologist Dr. Aroucha Vickers starting in June 2019, with more frequent visits following his stroke in November 2019. He was also evaluated by ophthalmologist Dr. [OMD3] on November 12, 2019. Lastly, most importantly, [Patient] was seen personally by glaucoma specialist, Dr. [OMD1].

Throughout the course of my care from April 2019 to March 2022, I regularly consulted with and sought the expertise of glaucoma specialist Dr. [OMD1] whenever concerns arose. In addition to our regular consultations, on at least two occasions, I requested that Dr. [OMD1] personally examine [Patient]. For instance, when [Patient]'s IOP was elevated on August 12, 2020, I immediately initiated treatment and arranged for him to see Dr. [OMD1] the following day. After evaluating him on August 13, 2020, Dr. [OMD1] agreed with my assessment and continued the management plan I had implemented. Similarly, on March 30, 2022, when [Patient] presented with a possible allergic reaction and increased IOP, I promptly adjusted his treatment and referred him back to Dr. [OMD1] for evaluation and potential surgical intervention. After Dr. [OMD1] examined him on April 7, 2022, he agreed with my assessment and determined that surgery was necessary. A trabeculectomy surgery was then scheduled for the next available date, May 18, 2022.

3. Allegedly, Dr. Caprioli stated to the patient in May 2022 that the surgery needed to be done sooner. If true, why wasn't it done sooner?

While I hold Dr. Caprioli in high regard, having observed his expertise during my time as a student volunteer at the UCLA Jules Stein Eye Institute, I am unaware of the specifics of his comment or whether he had full access to [Patient]'s medical history. My experience and training with respected ophthalmologists has taught me that glaucoma is a complex and chronic disease requiring individualized treatment based on thorough clinical evaluation. This approach, in collaboration with glaucoma specialist Dr. [OMD1], has always guided the care I provide.

Given [Patient]'s complex medical history—including low vision in his right eye, hypertension, diabetes, stroke, and heart disease—a cautious, balanced approach to his glaucoma management was essential. Initially, his condition was well-controlled, with stable IOP and optic nerve appearance. Over time, he did experience some fluctuations in IOP and visual field tests, which is common in glaucoma.

For example, a visual field test on November 12, 2019, revealed inferior defects, while a subsequent repeated test on January 6, 2020, showed marked improvement. This fluctuation is well-documented in glaucoma studies, which recommend repeating visual field tests to confirm progression. Despite these variations, [Patient]'s vision remained stable at 20/20 to 20/25 during my care.

Surgical intervention was considered and carefully timed based on ongoing assessments of [Patient]'s condition, ensuring that we balanced the potential benefits against the inherent risks. For instance, on August 12, 2020, when [Patient]'s IOP was elevated, I initiated immediate treatment and arranged for him to see Dr. [OMD1] within 24 hours. By then, his IOP had normalized, and surgery was not required. In fact, Dr. [OMD1] reduced the number of medications due to the stable IOP.

By March 30, 2022, however, when his IOP was again elevated and there were indications of potential visual field progression, it became clear that medical management alone was no longer sufficient. I adjusted his medications and promptly referred him back to Dr. [OMD1] for a surgical evaluation. Trabeculectomy surgery was deemed necessary and scheduled.

Throughout [Patient]'s care, surgical options were carefully weighed, and it was only after thorough clinical judgment and consideration of both risks and benefits that Dr. [OMD1] recommended surgery.

**Final Thoughts:**

I deeply empathize with the challenges [Patient] is facing right now, especially following his trabeculectomy surgery. While it is unfortunate that his vision has declined post-surgery, I can confidently say that every effort was made during my care to stabilize his vision and ensure his condition was managed appropriately. My thoughts are with him, and I remain hopeful for his continued progress.

I hope this response has clarified the evidence-based and collaborative approach I took in managing [Patient]'s glaucoma. His care was closely monitored, with timely interventions and a thorough evaluation of all treatment options. Throughout his care, I worked in close partnership with glaucoma specialist Dr. [OMD1] to ensure that any concerns, particularly elevated IOP, were promptly and appropriately addressed. Each decision was made with [Patient]'s best interests in mind, carefully weighing the risks and benefits of medical versus surgical treatment.

Given the complexity and duration of [Patient]'s care, attached is a table with key findings from each clinic visit that may be helpful in your review of the case.

Thank you for your time and service to all Nevadans and to the optometric profession.

Sincerely,

*/s/ [Licensee e-signature]*

[Licensee], O.D.

Attachment

| Date<br>Provider<br>Page # | Chief Complaint | Best Corrected Visual Acuity<br>Intraocular Pressure<br>Cup/Disc<br>Pertinent Findings | Diagnostic Testing | Treatment & Management |
|---|---|---|---|---|
| 11/15/2017<br>Dr. [OMD2] | New patient exam. Did not take pressure lowering drop Latanoprost for 2 months | 20/20<br>IOP 19<br>0.8 | Optic Nerve Photos: Deep central cup | - Restarted Latanoprost QHS OS<br>- RTC 3 months with Dr. [OMD2] Visual Fields and OCT Nerve |
| 12/6/2017<br>Dr. [OMD2] | Glaucoma follow-up | 20/20<br>IOP 15<br>0.8 | OCT Nerve: irregular distribution, moderate superior thinning<br>VF: MD -0.62 dB, blotchy non-specific defects<br>Gonioscopy: deep angle 40 degrees trace pigment<br>Pachymetry: CCT 542 average corneal thickness | - OCT consistent with “mild glaucoma”<br>- “IOP at good range”<br>- Continue with Latanoprost QHS OS<br>- RTC 3 months for repeat VF |
| 3/21/2018<br>Dr. [OMD2] | Glaucoma follow-up | 20/20<br>IOP 8<br>0.8 | VF: MD -2.27 dB, normal | - IOP doing well<br>- Continue with Latanoprost QHS OS<br>- RTC 4 months for IOP check, 6 months for repeat VF |
| 8/1/2018<br>Dr. [OMD2] | Glaucoma follow-up | 20/20<br>IOP 19<br>0.8 | None | - IOP target set to high teens<br>- Misses dose of medication twice weekly<br>- Continue with Latanoprost QHS OS<br>- RTC 4 months for repeat VF, if shows progression will lower target pressure and add a medication |
| 4/3/2019<br>Dr. [Licensee] | Glaucoma Follow-up - lost to follow-up - last seen Dr. [OMD2] 8 months ago on 8/1/2018 | 20/20<br>IOP 21<br>0.8 | VF: MD -0.49 dB, scattered non-specific points | - No signs of progression or loss of vision on VF<br>- IOP borderline. Questionable compliance with topical medications as patient was lost to follow-up for 7 months<br>- Continue with Latanoprost QHS OS - emphasized importance of using drops as instructed<br>- RTC 3 months for dilated exam with fundus photos |
| 7/10/2019<br>Dr. [Licensee] | Glaucoma Follow-up<br>“eyes are stable” | 20/20<br>IOP 20 dilated<br>0.8 | Fundus photos: Advanced cupping thin rim | - No signs of progression with C/D<br>- IOP borderline but measured dilated<br>- Continue with Latanoprost QHS OS<br>- RTC 3-4 months for IOP check, VF, OCT Nerve |
| 11/12/2019<br>Dr. [OMD3] | Glaucoma Follow-up<br>“severe pain left eye which all started last night” | 20/20<br>IOP 16<br>0.8 | VF: MD -5.65, arcuate scotoma inferior, suggestive of progression<br>OCT: superior thinning | - Superficial punctate keratitis noted<br>- No foreign body noted<br>- Ophthalmoplegic migraine - ordered SED rate and CRP to rule out temporal arteritis<br>- IOP borderline<br>- Continue with Latanoprost QHS OS. If IOP continues to be borderline at next visit will consider adding additional drops<br>- RTC 4 weeks with Dr. [OMD3] for IOP check and review MRI/CT/Blood work |
| 1/6/2020<br>Dr. [Licensee] | Glaucoma Follow-up<br>“vision has been same since last visit”<br>- stroke on 11/17/2019<br>- First MRI stroke<br>- Subsequent MRI normal | 20/20<br>IOP 16<br>0.8 | VF: MD -1.18, blotchy inferior defects, consistent with mild glaucoma, stable<br>OCT: superior thinning moderate, inferior thinning mild | - Set target IOP 16<br>- IOP is at target<br>- Testing is stable<br>- Continue with Latanoprost QHS OS<br>- Continue care with neurologist due to recent stroke<br>- RTC 3 months for VF due to h/o of recent stroke |

| | | | | |
|---|---|---|---|---|
| 8/12/2020<br>Dr. [Licensee] | Glaucoma Follow-up<br>- returns 4 months late<br>- "vision has remained stable since last visit" | 20/20<br>IOP 43, 30, 30<br>0.8 | VF: MD -3.57, arcuate scotoma inferior, paracentral scotoma, moderate glaucoma | - IOP OS is highly elevated<br>- Testing is stable<br>- Testing reviewed with patient and appears stable at this time. However, he will need stronger IOP control to preserve his vision in his only good eye. Rocklatan and Combigan instilled at slit lamp to verify good pressure lowering. Patient IOP did come down with these drops, however still elevated. Therefore, will add Dorzolamide OS BID as well; and have him start on Combigan OS BID, and Rocklatan OS QHS."<br>- Will have patient RTC tomorrow with Dr. [OMD1] for an IOP check |
| 8/13/2020<br>Dr. [OMD1] | Glaucoma Follow-up 1 day<br>- "Patient notes he mistakenly took Dorzolamide instead of Rocklatan last night"<br>- "Patient states his vision was 'not right' yesterday but it is back to normal today." | 20/20<br>IOP 9<br>0.8 | | - IOP OS greatly improved<br>- Continue Dorzolamide OS BID, Combigan BID OS, Restart Latanoprost QHS OS, Hold on Rocklatan OS QHS<br>- RTC 4 weeks with Dr. [OMD1 for short follow-up |
| 9/25/2020<br>Dr. [Licensee] | Glaucoma Follow-up<br>- returns 2 weeks late | 20/20<br>IOP 13<br>0.8 | | - IOP OS in good range<br>- Continue Dorzolamide OS BID, Combigan OS BID, Latanoprost OS QHS<br>- RTC 3-4 months for complete dilated eye exam with fundus photos and 24-2 VF OS |
| 1/22/2021<br>Dr. [Licensee] | Glaucoma Follow-up | 20/20<br>IOP 9<br>0.8 | Fundus photo: increased C/D, parapapillary atrophy<br>VF: MD -4.60, arcuate scotoma superior/inferior, paracentral scotoma, difficult to compare secondary to variability | - IOP OS in within great range<br>- Continue Dorzolamide OS BID, Combigan OS BID, Latanoprost OS QHS<br>- RTC 3-4 months for short IOP check and OCT Nerve with Dr. [OMD1] |
| 4/28/2021<br>Dr. [Licensee] | Glaucoma Follow-up<br>- "sometimes forgets to use drops that need to be used BID, only used QD"<br>- "today he has not used dorzolamide"<br>- "two weeks he is feeling left eye with pain more when he touches his eye, he also claims he frequently headaches, when he has headaches sometimes vision is affected, was evaluated by Neurologist two days ago, was explained needed to do new MRI to check his head." | 20/20<br>IOP 11<br>0.8<br>Blocked meibomian gland left upper lid | OCT Nerve: severe superior and inferior thinning | - IOP OS is below target<br>- Testing change<br>- blocked gland left upper lid - recommend warm compresses twice a day and artificial tears four times a day<br>- Continue care with neurologist for headaches<br>- Continue Dorzolamide OS BID, Combigan OS BID, Latanoprost OS QHS<br>- RTC 3 months for VF |
| 5/26/2021<br>Dr. [Licensee] | Unscheduled visit | 20/20<br>IOP 13 | | - Posterior blepharitis and chalazion Left Upper Lid: Started Maxitrol ointment BID OS, hot |

| | | | | |
|---|---|---|---|---|
| | - pain in left eye, worse each day<br>- corner of left eye itches all day long<br>- Vision worsen since Friday; only sees poorly when there isn't much light<br>- administers drops the corner of left eye burns for a couple of seconds<br>- did not use Combigan or Dorzolamide this morning | 0.8<br>Chalazion left upper lid | | compresses 5-10 minutes twice daily, Retaine MGD QID OU for symptoms of irritation<br>- IOP OS continues to be in great range<br>- Continue Dorzolamide OS BID, Combigan OS BID, Latanoprost OS QHS<br>- RTC 4 weeks for follow-up |
| 6/30/2021<br>Dr. [Licensee] | Follow-up for chalazion one month<br>- "Patient states there is no longer any pain and swelling has gone down a lot since his last visit. Patient is compliant with medicated ointment."<br>- "Patient does not do hot compresses" | 20/20<br>IOP 20<br>0.8<br>Chalazion left upper lid | | - Resolved chalazion LUL<br>- Stop Maxitrol ointment BID OS once done with tube<br>- Continue hot compresses 5-10 minutes twice daily, lid scrubs, and Retaine MGD QID OU for symptoms of irritation<br>- IOP OS borderline<br>- Continue Dorzolamide OS BID, Combigan OS BID, Latanoprost OS QHS<br>- RTC as scheduled 7/28/2021 |
| 7/28/2021<br>Dr. [Licensee] | Glaucoma follow-up 4 week<br>- Patient had itching and swelling in left eye<br>- Patient restarted Maxitrol after being told to discontinue at last visit<br>- "Patient states ointment has been helping with discomfort on the left eye."<br>- "Patient states his peripheral vision is doing very well." | 20/20<br>IOP 16<br>0.8<br>Chalazion left upper lid<br>1+ Nuclear sclerosis cataract | VF: MD -6.25, paracentral scotoma, difficult to compare secondary to variability | - IOP OS at target<br>- Continue Dorzolamide OS BID, Combigan OS BID, Latanoprost OS QHS<br>- Chalazion left upper lid - Restarted Maxitrol ointment BID OS, hot compresses 5-10 minutes twice daily, Retaine MGD QID OU for symptoms of irritation<br>- RTC 2 months |
| 9/22/2021<br>Dr. [Licensee] | Glaucoma follow-up<br>"Is feeling left eye is better and says chalazion is improved"<br>- Heart surgery two days ago | 20/20<br>IOP 16<br>0.8<br>1+ Nuclear sclerosis cataract | | - Heart surgery 9/20/2021 Patent Foramen Ovale closure procedure<br>- IOP OS at target<br>- Resolved chalazion LUL - Stop Maxitrol ointment BID OS. Continue hot compresses 5-10 minutes twice daily, lid scrubs daily, Retaine MGD QID OU for symptoms of irritation<br>- Continue Dorzolamide OS BID, Combigan OS BID, Latanoprost OS QHS<br>- RTC 3-4 months for comprehensive dilated exam with VF and fundus photo |
| 1/12/2022<br>Dr. [Licensee] | Glaucoma follow-up<br>- "Blurred vision usually due to | 20/20<br>IOP 16 dilated<br>0.8<br>1+ Nuclear | Fundus photos: increased C/D advanced cupping<br>VF: MD -11.02, blotchy inferior and superior defects, paracentral | - IOP OS at target even with dilation<br>- But given possible progression in testing, will increase Dorzolamide OS from twice a day to three times a day, continue Combigan OS BID, |

| | | | | |
|---|---|---|---|---|
| | diabetes” | sclerosis cataract | scotoma, suggestive of progression | Latanoprost OS QHS<br>- Old chalazion LUL - No signs of infection today. Continue hot compresses 5-10 minutes twice daily, lid scrubs daily, Retaine MGD QID OU for symptoms of irritation<br>- RTC 3 months for repeat VF to confirm defects |
| 3/30/2022<br>Dr. [Licensee] | Unscheduled visit - 2.5 months<br>- “Red rash on his skin around his eyes”<br>- Used “warm wash cloth around which helps with irritation” | 20/25<br>IOP 27<br>0.8<br>1+ Nuclear sclerosis cataract | | - IOP OS elevated<br>- Possible allergic reaction to glaucoma medication<br>- Stop Dozolamide OS TID, continue Combigan OS BID, Latanoprost OS QHS<br>- Start Rhopressa QHS OS<br>- May use petroleum jelly around eye lids as needed to help with irritation<br>- RTC 1 week with Dr. [OMD1] |
| 4/7/2022<br>Dr. [OMD1] | 1 week follow-up visit<br>- Did use Rhopressa QHS OS however, pt is only using Combigan once a day<br>- feels left eye is better but still has stand in the left eye, itching in the left upper lid, dry skin, intermittent eye pain 5-6 on scale of 1-10, denies any worsening of vision but states he may be losing peripheral vision | 20/25<br>IOP 21<br>0.95<br>1+ Nuclear sclerosis cataract | | - IOP OS uncontrolled<br>- Recommends trabeculectomy in near future time frame next available<br>- Continue same glaucoma medications until surgery date 5/18/2022<br>- Continue Rhopressa QHS OS, Combigan BID OS, Latanoprost QHS OS |