Clinical Connection

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SUMMER 2026

Welcome to the inaugural edition of EyeCare Partners *Clinical Connection*!

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National Medical Director, Clinical Integration

This newsletter is built around a simple idea: When we share knowledge and perspectives, we deliver better care for our patients.

Clinical Connection is designed to help you care for patients locally, efficiently and with access to the latest capabilities. Each issue will feature timely topics in eye care explored by our optometric residents and complemented by insights from local ophthalmology and optometry colleagues, bringing both emerging thinking and real-world application into focus. You'll also find introductions to our newer doctors and updates on educational opportunities, new technologies, clinical research and practical ways to stay connected.

We hope this serves as a meaningful way to stay informed, strengthen connections and support our shared goal of delivering the best possible care to the patients and communities we serve.

We welcome your ideas and suggestions for future issues. Thanks for joining us on the *Clinical Connection* journey.

HOT TOPIC

Life in Focus: The Rise of Premium Intraocular Lens (IOL) Technology

Cataract surgery is among the most commonly performed surgical procedures worldwide, with approximately 3.8 million operations conducted in the U.S. each year.[1,2] Since its origin in 1949, monofocal IOLs served as the undisputed standard of cataract care, reliably restoring distance vision while accepting that patients would remain dependent on spectacles for near and intermediate tasks.[3] Though effective, this approach increasingly fell short of evolving patient expectations.

As the global population ages and active lifestyles become the norm across older demographics, demand for spectacle independence at all distances has grown substantially. Patients presenting for cataract surgery today are better informed, have greater visual demands and are more likely to request functional near vision than ever before. Toric, multifocal and extended depth of focus (EDOF) IOL options now offer clinicians powerful tools to meet individualized patient goals. Optimal patient satisfaction begins

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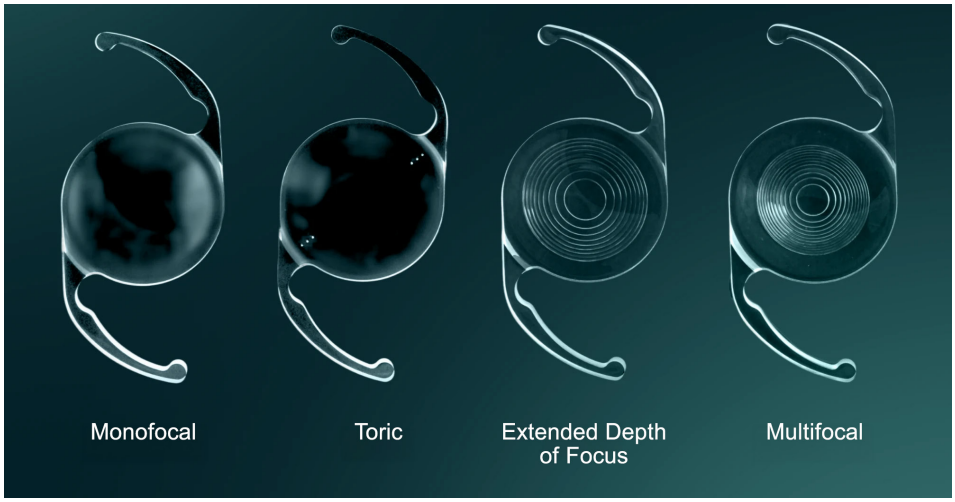
long before the operating room with evidence-based IOL selection tailored to the patient's lifestyle and visual demands.

Lens Categories

Monofocal IOLs represent the foundational design in cataract surgery, featuring a single fixed focal point. The target of this focal point is most commonly set for distance. Unlike premium lens designs, monofocal IOLs do not address pseudo-presbyopia, meaning patients should be counseled preoperatively that reading glasses or bifocals will be required for near and intermediate tasks following surgery. For those patients with the goal of good near vision uncorrected, particularly myopic patients who habitually remove their spectacles to read, it is possible to set the target for near. In this case, spectacle correction would continue to be necessary for clear distance vision. A monovision strategy that targets the dominant eye for distance and the fellow eye for near can be considered in patients who are accustomed to monovision correction prior to cataract surgery. Extensive education regarding binocular vision and intermediate distance limitations is imperative with this methodology.

Spherical monofocal IOLs are the lens of choice for patients looking for a lens design fully covered by medical insurance. Spherical monofocal IOLs do not correct for astigmatism, meaning patients will likely require spectacle correction for best vision at all distances following surgery. The exception to this rule is patients with minimal corneal astigmatism, who can expect good distance vision uncorrected. Toric multifocal IOLs are a premium lens option for patients with greater than or equal to 0.75D to 1.00D of corneal astigmatism who wish for spectacle independence at distance. Limbal relaxing incisions (LRIs), small arc-shaped peripheral corneal incisions, can be performed to correct for mild corneal toricity not meeting the threshold for a toric IOL.[4]



Re:Vision. (n.d.). Premium lenses. https://www.revision.nz/premium-lenses

Despite their limitations, monofocal lenses remain an excellent choice for many candidates, including those with coexisting ocular pathology such as macular degeneration, diabetic retinopathy or significant dry eye disease that would preclude reliable outcomes with premium IOLs. Monofocal lenses are also well-suited for patients who prioritize the highest possible optical quality at distance, such as those who drive frequently or work in visually demanding environments, and for whom spectacle dependence for near tasks is an acceptable trade-off to pristine distance vision.

Multifocal IOLs represent a significant advancement in IOL technology, designed to provide functional vision across a range of distances by dividing incoming light into two or more discrete focal points. This is achieved through either diffractive or refractive optical designs. Diffractive multifocal lenses use a series of concentric rings etched onto the lens surface to split light between distance and near focal points, while refractive designs rely on alternating optical zones of differing power. Trifocal IOLs represent the current standard among premium multifocal designs, adding a dedicated intermediate focal point to address computer and arm's length tasks that bifocal multifocals historically underserved.[5] The primary advantage of multifocal IOLs is the potential for meaningful spectacle independence across all distances, which carries high appeal for active, visually demanding patients. However, clinicians must engage in thorough preoperative counseling regarding the inherent optical trade-offs of multifocal designs, most notably the increased incidence of photic phenomena including halos, glare and starbursts, particularly under mesopic conditions. Contrast sensitivity may also be modestly reduced compared to monofocal IOLs. Ideal candidates are highly motivated patients with healthy macular function, minimal corneal irregularity and realistic expectations. Patients with significant ocular comorbidities, pupillary abnormalities or a history of prior refractive surgery should be approached with caution or steered toward alternative lens platforms.[6]

Overview of Lens Categories

	Insurance Coverage	Spectacle Dependence	Ideal Candidate
Spherical Monofocal IOLs	Typically fully covered	Expect spectacle correction for best vision at all distances	• Distance target: anyone • Near target: myopes preferring to continue to read without spectacles • Monovision target: established monovision contact lens wearers
Toric Monofocal IOLs/Limbal Relaxing Incisions	Out-of-pocket cost	Good distance (or near) vision without glasses, will need spectacle correction for all tasks arm's length or closer	
Multifocal IOLs	Out-of-pocket cost	Greatest independence from spectacles, may need small reading prescription for fine print	• Patients wanting the greatest independence from spectacles • Established multifocal contact lens wearers • Absence of ocular pathology
Extended Depth of Focus (EDOF) IOLs	Out-of-pocket cost	Moderate independence from spectacles, good distance and intermediate vision, some functional near vision, expect small reading prescription for near work	• Patients wanting moderate independence from spectacles • Concern for difficulty adapting to multifocal design • Absence of ocular pathology

Extended depth of focus (EDOF) IOLs represent a compelling middle ground between monofocal and multifocal designs, engineered to elongate the eye's focal range into a continuous corridor of vision rather than creating discrete, separate focal points. This is achieved through a variety of optical strategies depending on the platform, including wavefront manipulation, pinhole optics and non-diffractive refractive technologies.[6] The primary clinical advantage of EDOF IOLs is a significantly reduced incidence of halos and glare compared to multifocal lenses, making them particularly attractive for patients who are concerned about nighttime driving or work in low-light environments. Ideal candidates include patients seeking meaningful reduction in spectacle dependence for distance and intermediate tasks, and who are unwilling to accept the dysphotopsia risk associated with multifocal IOLs. EDOF lenses are also well-suited for patients with mild macular changes or modestly reduced contrast sensitivity in whom a multifocal IOL would be contraindicated, as well as those with active lifestyles who prioritize visual quality over complete near spectacle independence. Patients should nonetheless be counseled that reading glasses will likely still be required for prolonged or demanding near tasks.

Screening and Preparing Patients

Careful patient screening is essential prior to premium IOL implantation. Significant macular pathology including age-related macular degeneration, diabetic macular edema and epiretinal membrane formation represents a primary contraindication to multifocal and EDOF lenses, as compromised retinal function will limit visual

potential and amplify dissatisfaction. Irregular corneal astigmatism, as seen in keratoconus, is another contraindication for premium IOL designs. While not an outright contraindication, ocular surface disruption secondary to dry eye disease will limit visual quality, especially in patients with premium lens options. Optimization of the ocular surface will allow for best vision potential following surgery. Dry eye disease should be aggressively managed prior to surgical planning, as it can destabilize preoperative measurements and reduce postoperative outcomes. A history of refractive surgery can also affect the quality of preoperative measurements and has the potential to limit the accuracy of hitting a specific postoperative target.

Clinical outcomes data for premium IOLs are encouraging, though the importance of appropriate patient selection and preoperative counseling is critical. Spectacle independence confers benefits that extend well beyond the exam lane. Patients consistently report improved quality of life, greater freedom in daily activities and a reduced burden of corrective eyewear that many describe as transformative.

James McHale, M.D., Director of Cataract Surgery at Columbus Ophthalmology Associates, captures this sentiment well, noting: "The revolution of lens implant development has been critical in providing patients with the best possible vision they can obtain given their visual potential through cataract surgery. Astigmatism correction is a given today and can be achieved through toric IOL implantation or limbal relaxing incisions for lower amounts of astigmatism. I have been infinitely impressed with patients' acuities and focusing capabilities regarding modern day, multifocal lens implants. We try to provide patients with a complete and improved range of focus, which reduces or completely absolves a patient's dependence on glasses."

U.S. FDA clinical trial data echoes this optimism, demonstrating that 99% of patients who received multifocal IOLs would choose the same lens again — although those same data reveal that 12.6% of multifocal IOL patients reported severe difficulty with halos, compared to just 0.9% of monofocal IOL patients.[5] This contrast is not a contradiction; rather, it reflects the reality that when patients are appropriately selected and thoroughly counseled, even lenses with inherent optical trade-offs can deliver outstanding satisfaction. Ultimately, these figures reinforce a central theme in premium IOL practice: Exceptional outcomes are achievable, but remain contingent upon matching the right lens to the right patient and anchoring expectations in clinical reality.

Setting Patients up for Success

The expanding landscape of IOL technology has transformed cataract surgery into an opportunity to meaningfully optimize a patient's lifelong visual function. As available IOL design options continue to grow, so too does the responsibility of every clinician involved. By initiating identifying conditions that may influence candidacy, managing ocular surface disease preoperatively and calibrating patient expectations well in advance of the surgical consultation, the referring clinician can dramatically streamline the process and set both the patient and surgeon up for success. In an era of rapidly advancing IOL technology, the clinicians who invest in staying current with the evidence will be best positioned to guide their patients toward the visual outcomes they deserve.

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Life in Focus: The Rise of Premium Intraocular Lens (IOL) Technology

The Surgical Perspective

Samantha Shockman, M.D.

What are the most common reasons a patient is not a good candidate for an advanced technology intraocular lens (ATIOL)?

Samantha Shockman, M.D.: Candidacy is different for each ATIOL type. I group ATIOLs into broad categories: astigmatism correcting (toric), diffractive trifocal, extended depth of focus (EDOF) and Light Adjustable Lenses (LALs). Several other ATIOLs have smaller niches, such as a pinhole IOL, but these are typically used in unusual cases.

As a rule, patients are not a good candidate for any ATIOL if they have irregular corneal astigmatism. There are few exceptions such as stable ectasias with a component of regular astigmatism that may benefit from a toric IOL, or a pinhole IOL to help reduce optical aberrations when a patient has an irregular cornea.

Generally, any patient with regular corneal astigmatism is a candidate for a toric IOL. Macular and optic nerve pathology are acceptable for toric IOLs, but severe vision limitation may make astigmatism correction less meaningful to a patient's visual prognosis. It is important to have a frank discussion with these patients to see if the out-of-pocket costs are worthwhile.

Range of vision lenses require more careful patient selection. Patients with significant macular or optic nerve disease are poor candidates for multifocal lenses.

Diffractive trifocal lenses split light to give patients a wide range of vision without spectacles. While most patients are happy, splitting light can result in poorer contrast sensitivity, lessened quality of vision and halos or glare at night. Macular and/or optic nerve disease also have contrast sensitivity reduction and poorer quality of vision. To avoid significant vision challenges, it is not recommended to use diffractive trifocal IOLs in patients with macular or optic nerve disease.

EDOF lenses do not provide as much spectacle-free range of vision as diffractive trifocals. Patients often still need reading glasses, but their loss of contrast sensitivity, glare or halo at night and reduced quality of vision are not as severe. This IOL is thought to be a bit more "forgiving" when patients have some mild macular or optic nerve changes and may be considered in these circumstances. It can also be considered in healthy eyes for patients who want some range of vision with less night vision compromise.

What do you wish referring optometrists would consistently address before sending a cataract patient for a surgical consult?

Samantha Shockman, M.D.: The number one reason patients need to delay surgery is a poor ocular surface. Most commonly from dry eye, a poor ocular surface makes biometry measurement inaccurate. We often need to spend time optimizing the ocular surface and repeating measurements until they are satisfactory to accurately choose a lens power. It would be extremely helpful, and advantageous to the patient, if their dry eye or other surface disease was optimized prior to coming to their cataract surgery consultation. This allows for accurate measurements at their initial visit and more informed decisions for lens selections, while preventing surgery delays. Even patients with healthy corneas would benefit from using preservative-free tears three to four times daily for a week leading up to their consult.

Where do optometrists add the most value in the cataract surgery journey?

Samantha Shockman, M.D.: I love when patients are directly referred from their optometrist with data to review. I look at each patient's referral before I introduce myself. Often the referring optometrist has known the patient for years, resulting in a strong personal relationship. Having long-term relationships allows the referring optometrist to have insight into a patient's personality and goals that I can't gather in a single consultation visit. Referrals with suggestions or informative tidbits are extremely valuable. Examples include "patient loves monovision," "patient's personality would not work well with a multifocal intraocular lens,"

"patient hates glasses," "patient tried monovision and did not tolerate," "patient loves to take glasses off to read," and "patient is very scared of surgery." This is such useful information!

Just as important is the patient's continuity of care with their primary eye care provider after cataract surgery. I tell patients to go back to their referring optometrist for any refractive needs and continue comprehensive eye care. While cataract surgery can be amazing, it does not prevent further eye disease. Patients still need comprehensive care.

If a close family member needed cataract surgery, which IOL would you recommend and why?

Samantha Shockman, M.D.: I can answer this question from experience as I've had many family members and friends undergo cataract surgery after I became a surgeon. There is no single lens I recommend for everyone. If there was a perfect lens, I would recommend it to my family and every patient. Choosing an IOL is unique to each person based on ocular health, personality and overall vision goals.

I've had a parent who was thrilled with his extended depth of focus (EDOF) IOLs (his goal was to reduce the need for glasses but he wanted to minimize both halos at night and contrast sensitivity reduction). I've had an in-law receive toric IOLs for distance vision because really crisp vision was his most important goal and he didn't mind reading glasses. I've had family members choose standard IOLs, choosing to wear full-time glasses because they love how they look in glasses. Family friends have used IOLs across the board, and all have been happy at the end. The most critical part of the cataract surgery journey is spending adequate time educating the patient so they can make a truly informed decision on IOL choice based on their goals (assuming candidacy). Misinformation or not being well informed of options can result in unhappy patients because that is when patient expectations don't line up with reality after surgery.

NEW FACES: BEYOND THE BIO

Kinsley Gossard, O.D.

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Q&A

Why did you join Cincinnati Eye Institute (CEI)?
I was drawn to CEI because of its reputation for providing exceptional patient care and commitment to clinical excellence. I wanted to be part of an organization that values collaboration, innovation and continued learning.

What led you to this career?
I've always been interested in healthcare and helping people improve their quality of life. Optometry offered the perfect combination of patient care, problem-solving and lifelong learning, while allowing me to build meaningful relationships and make a tangible difference in patients' lives each day.

Tell us a little about your path here. Which areas of eye care are you especially passionate about?
My journey is driven by a desire to help patients see and feel their best. Along the way, I've developed interest in dry eye disease. I enjoy working with patients to identify the underlying causes of their symptoms and create personalized treatment plans that can significantly improve their comfort and quality of life.

When you're not in the clinic, how do you like to unwind?
I enjoy reading a good book or discovering a new TV show. When the weather is nice, I take advantage of any opportunity to spend time outside.

Tell us about your family and any pets.
I grew up in a large, close-knit family and have more cousins than I can count. At home, I have two cats, Bodhi and Kaiju, who keep life entertaining and are always eager to be involved in whatever I'm doing.

If you weren't working in eye care, what would you do?
If I weren't in eye care, I would enjoy being a librarian or working at a greenhouse.

Rosa Balcells Gonzalez, M.D.

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Q&A

Why did you join Cincinnati Eye Institute (CEI)?
I came to Cincinnati years ago for my oculoplastics fellowship and left with incredible memories of the city and CEI. I was impressed by the outstanding level of ophthalmology and surgery, as well as the sense of community among physicians and staff. CEI has a unique culture and world-class expertise.

After building my career in Chile, I had the opportunity to return to CEI as an attending physician. It felt like coming home, except this time, I knew all the good restaurants.

Tell us a little about your path here. Which areas of eye care are you especially passionate about?
I'm an oculoplastic surgeon, the perfect specialty for someone who loves ophthalmology and surgery. It combines delicate eye care with the artistry and precision of plastic surgery to help patients see better, feel better and often look better, too.

I completed fellowship training at CEI before returning to Chile, where I built a busy oculoplastics practice and served on several medical organization boards. I was honored to become president of the Chilean Society of Ophthalmology.

About a year ago, my children moved to the U.S. for college. CEI offered me the opportunity to return, which was the perfect moment for a new family adventure and new chapter in my career.

How would you describe your style with patients?
I genuinely love seeing patients. I have the privilege of meeting people from different backgrounds and hearing their stories. I try to create an environment where patients feel comfortable asking questions and know they are being heard.

My style is warm, approachable and thorough. Understanding a diagnosis is just as important as treating it, so I take the time to explain things clearly. My goal is for patients to leave feeling informed, cared for and hopefully a little less worried than when they walked in.

Tell us about your family and any pets.
My husband and I have five children and two dogs. We're getting close to becoming empty nesters, but our house is still the neighborhood gathering spot for kids, friends, family and occasionally anyone who smells dinner cooking. Life is rarely quiet, and we wouldn't have it any other way.

When you're not in the clinic, how do you like to unwind?
I love cooking and gathering family and friends around the table for a good meal. I also enjoy sewing, knitting, reading and taking care of plants. Some people relax by doing nothing. I apparently relax by starting another project.

If you could travel anywhere in the world, where would you go?
I've been fortunate to travel to many wonderful places and loved every experience. Asia is still at the top of my list. I would love to visit Japan, Korea and China to experience their history, culture, food and traditions. As someone who loves food, there's a good chance part of my itinerary would simply be to eat something amazing and ask for the recipe.

Kelly Klimo, O.D., M.S.

cincinnatieye.com/doctors/kelly-klimo-od

Q&A

What led you to this career?
I knew I wanted to be an optometrist since age 10. When looking in the mirror one day, I saw my pupils constrict for the first time and it terrified me. My dad, a physician, explained how the pupils, eyes and brain work together. Since then I've been hooked.

Why did you join Cincinnati Eye Institute (CEI)?
I was fortunate to complete my optometry residency at CEI after optometry school. After learning from all the amazing CEI surgeons and optometrists across all subspecialties, it was a "no brainer" when I was given the opportunity to stay.

What can people expect when they see you?
Patients can expect a comprehensive, detail-oriented exam. I value patient education and ensuring I describe findings in ways patients easily understand. I also value patient interaction and exam time. I want patients to feel like they have a say in their treatment without feeling rushed.

Tell us about your family and any pets.
I married my husband, who I've known since high school, in August 2025. We are from northeast Ohio but are so happy to live in Cincinnati. We have a 6-year-old mini Bernedoodle named Nash. He is the highlight of every day.

If you weren't working in eye care, what would you do?
I would love to be a sports analyst for a college football team. I am a mega-fan of college football, especially The Ohio State University (go Bucks!). I also love breaking down player tendencies, offenses and defenses.

What was your most unusual job?
My most unusual job was a meat clerk at a grocery store. I graduated college in 2020 at the peak of the COVID-19 pandemic and thought it would be a good use of my time to give back to the community. The manager thought I would be best in the meat department. I handled steak, sausages, chicken and fish all day. If you need any steak recommendations, I'm your girl!

Mauricio A. Perez, M.D.

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Q&A

Why did you join Cincinnati Eye Institute (CEI)?
CEI is one of the premier U.S. ophthalmology practices, with a longstanding reputation for excellence in patient care, education and innovation. I was attracted by the opportunity to work alongside outstanding colleagues while continuing to care for complex corneal, cataract and anterior segment patients. The strong academic connection with the University of Cincinnati and possibility to teach future ophthalmologists made the decision especially meaningful.

What led you to this career?
I have always been fascinated by the combination of science, technology and ability to make a direct impact on people's lives. Ophthalmology offers the unique opportunity to restore vision and improve quality of life, often with immediate results. Helping someone see better after surgery is one of the most rewarding experiences in medicine.

Tell us a little about your path here. Which areas of eye care are you especially passionate about?
After completing my ophthalmology residency at the University of Chile, I pursued four years of subspecialty training in cornea, refractive surgery, complex cataract surgery and anterior segment reconstruction through fellowships in Chile, the U.S. and Canada. I also practiced as a staff specialist in Sydney, Australia before joining CEI.

I am passionate about complex cataract surgery, anterior segment reconstruction, corneal transplantation and refractive surgery. I enjoy managing challenging cases and helping patients regain vision they may have thought was permanently lost.

If you weren't working in eye care, what would you do?
I joke that my alternative careers would have been point guard for the 1998 Chicago Bulls or lead guitarist for Pearl Jam. Realistically, I would still have chosen a profession that involved teaching, creativity and problem solving.

What is the best part of your job?
The best part is seeing the difference restored vision makes in someone's life. Whether it is helping a patient return to driving, reading, working or seeing their loved ones more clearly, those moments never get old. I enjoy teaching residents, fellows and colleagues, and contributing to ophthalmic surgery advances.

When you're not in the clinic, how do you like to unwind?
I spend time with my wife and daughters, travel, play guitar and piano, and watch and play basketball and tennis. Music and sports have always been important parts of my life, and I especially enjoy playing with family and friends.

What is one thing about you that might surprise your colleagues or patients?
I play guitar, piano and drums and performed in a family band. I speak multiple languages and had the opportunity to live and train in several countries throughout my career.

What is your favorite band and sports team?
My musical tastes are eclectic. Pearl Jam and Pink Floyd have always been among my favorites. As for sports, I have been a National Basketball Association (NBA) fan for as long as I can remember. I grew up admiring Michael Jordan and still follow every game. I travel to watch the Indiana Pacers whenever I can and look forward to the return of their star player so the team can have a chance at the NBA finals.

CLINICAL TRIALS NEAR YOU

These clinical trials are actively enrolling patients.
Questions? Email: megankingdon@eyecare-partners.com.

Retina

Condition	Sponsor	Description
Neovascular Age-Related Macular Degeneration (nAMD)	REGENXBIO	RGX-314-Bilateral Treatment Substudy
Geographic Atrophy - Age-Related Macular Degeneration (GA-AMD)	Genentech	A Phase IIA Open-Label, Single-Arm, Multicenter Study to Optimize Subretinal Delivery of Opregen in Patients with Geographic Atrophy Secondary to Age-Related Macular Degeneration
Stargardt Disease	Ascidian Therapeutics	ACDN-01-001 Open-Label, Single Ascending Dose Study to Evaluate the Safety, Tolerability, and Preliminary Efficacy of Subretinally Delivered ACDN-01 in Participants with ABCA4-Related Retinopathy (Stargardt's/Rod-Cone Dystrophy)
Neovascular Age-Related Macular Degeneration (nAMD)	Genentech	A Phase IIIb/IV, Multicenter, Visual Assessor Masked Study of the Efficacy and Safety of the Port Delivery System with Ranibizumab in Patients with Neovascular Age-Related Macular Degeneration Previously Treated with Intravitreal Agents Other than Ranibizumab
Neovascular Age-Related Macular Degeneration (nAMD)	Genentech	Iridex Laser SubStudy
Geographic Atrophy - Age-Related Macular Degeneration (GA-AMD)	Regeneron	A Multicenter, Randomized, Double-Masked, Placebo-Controlled Phase 3 Study of the Efficacy, Safety, and Tolerability of Subcutaneously Administered Pozelimab in Combination with Cemdisiran or Cemdisiran Alone in Patients with Geographic Atrophy Secondary to Age-Related Macular Degeneration (AMD)
Neovascular Age-Related Macular Degeneration (nAMD)	4D Molecular Therapeutics (4DMT)	Phase 3 Clinical Trial in Patients with Neovascular (Wet) Age-Related Macular Degeneration (nAMD). The primary objective of the study is to establish the efficacy and safety of 4D-150, an AAV based genetic medicine, administered to a single eye as a single injection in adults with nAMD
Stargardt Disease	SpliceBio	An Observational Study in Subjects to Follow the Progression of Stargardt Disease Type 1 (STGD1) Caused by Bi-Allelic Autosomal Recessive Mutations in the ATP Binding Cassette Subfamily A Member 4 (ABCA4) Gene
BEST1 Gene	Opus Genetics	A Phase 1b/2a, Open-Label, Dose-Exploration Basket Study to Investigate the Safety and Tolerability of Subretinally Injected OPGx-BEST1 Administered in Patients with Either Autosomal-Dominant BEST1 Disease (Best Vitelliform Macular Dystrophy [BVMD] or Autosomal-Recessive Bestrophinopathy (ARB)
Macular Telangiectasia (MacTel)	Neurotech Pharmaceuticals	Phase IV Safety and Efficacy Extension

Anterior Segment

Condition	Sponsor	Description
Age-Related Macular Degeneration (AMD)	Samsara Vision	PMA-Supplement (Concerto Study) in the U.S. for our 2nd Generation Implantable Miniature Telescope (SING IMT)
Corneal Dystrophy	Mass Eye and Ear	ExCrossV ExVivo Corneal Crosslinking of Donor Corneal Tissue for Vascularized High-Risk Keratoplasty
Cataract Surgery	Ocusun/Lexitas	A Multicenter, Randomized, Double-Masked, Placebo-Controlled Pilot Study to Evaluate the Efficacy and Safety of ZOC2017217 in Subjects with Age-Related Cataract
Primary Open-Angle Glaucoma (POAG)	Glaukos	A Prospective, Multicenter Study of the Preserflo Microshunt in Subjects with Primary Open-Angle Glaucoma Who Have Failed Previous Medical and Surgical Treatment
Primary Open-Angle Glaucoma (POAG)	SpyGlass Ophthalmics	A Prospective, Multicenter, Randomized, Masked, Controlled Study to Evaluate the Safety and Efficacy of the Bimatoprost Implant System (78 mcg) Used in Combination with the SpyGlass IOL Compared to Timolol Maleate Ophthalmic Solution, USP, 0.5%

MARK YOUR CALENDAR

Be on the lookout for our **fall continuing education** event at Madtree Parks & Rec in Summit Park. More details coming soon.

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