What Collaboration Can Do: A Pediatric Ophthalmologist, an Optometrist, and Putting the Patient First

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Collaboration between the practitioners of optometry and ophthalmology is relatively infrequent. When it occurs, the synergy achieved lays the groundwork for best patient outcomes. Here, Dr. Leonard Press of PracticeUpdate speaks with two clinicians who have established a strong working relationship based on mutual respect and their desire to put the patient first.

Dr. Press: Good day, doctors. Can you tell us a bit about your backgrounds?

Dr. Lenart: I practice pediatric ophthalmology in Redmond, Washington. After obtaining my MD and PhD from the University of Pennsylvania, I did my residency at the Mayo Clinic and pediatric ophthalmology fellowship at Emory University. After completing my fellowship, I joined the pediatric ophthalmology practice of Dr. Howard Freedman in Redmond.

Dr. Torgerson: My practice, dedicated to vision development and rehabilitation, is Alderwood Vision Therapy Center in Lynnwood, Washington. I graduated from Pacific University College of Optometry, where I am an adjunct professor. I am board-certified in vision therapy and development by the College of Optometrists in Vision Development, and have served as that organization's president.

Dr. Press: It is uncommon for ophthalmologists and optometrists in private practice to have a collaborative working relationship involving strabismus. How did the two of you get together?

Dr. Lenart: In the practice that I joined and subsequently purchased, Dr. Freedman worked together with a pediatric optometrist, Dr. Karen Preston. It seemed natural to me that there should be synergy between the two professions.

Dr. Torgerson: I was aware of Dr. Lenart's reputation in the community of being receptive to doing whatever was in the best interests of the patient and not worrying about the dogma that seems to interfere with the patient being given options for treatment.

Dr. Press: Can you give us an example of the types of cases on which you collaborate?

Dr. Lenart: An example is early-onset accommodative esotropia. I prefer not to do surgery on a child younger than 6 months of age. I like to refer to Dr. Torgerson to see what she can accomplish with lenses, prisms, and/or vision therapy. In most instances when the child has vision therapy the outcome is more stable, and in some cases surgery can be avoided altogether.

Dr. Torgerson: I recall the case of child who had monocular nystagmus. Whenever I see something unusual like this, my comfort level is higher when I collaborate with Dr. Lenart at the outset. An MRI revealed that the child had a brain tumor, but thankfully he did well once the tumor was removed.

Dr. Press: Are there instances in which you find that you are surprised by the outcomes, even now that you've been collaborating for a while?**Dr. Lenart:** I had a patient with thyroid ophthalmopathy who experienced large-angle esotropia. Normally I wouldn't have considered vision therapy in such a case, but

there's a limit to how many millimeters you can recess. After the third surgery, when the patient still had restrictive gaze, I referred to Dr. Torgerson. What she was able to accomplish reminded me that I shouldn't have waited that long, and that the patient should always be given the option of vision therapy.

Dr. Torgerson: We share a case in which a patient had an orbital dermoid of the right lateral rectus that was removed by an oculoplastic surgeon but resulted in paralysis of the muscle. Dr. Lenart referred her to me and we were able to increase her range of motion and fusion so that surgery wasn't necessary. What really touched me was that Dr. Lenart was genuinely pleased that surgery could be avoided. Even in instances where he feels surgery is indicated, he will factor in my opinion and that of the patient.

Dr. Press: So now, for the obvious question—why is it that collaboration to the extent that the two of you have is so rare?

Dr. Lenart: I'm not entirely sure. Perhaps it was my 2-year stint in the Peace Corps before I went to medical school that gave me a broader perspective than that held by some of my colleagues. Perhaps it was my discipline or dedication that was required to obtain a PhD in biophysics while going to medical school. But, the key thing is that I really don't mind challenging dogma, and a lot of the reluctance of my colleagues to collaborate is based on that more so than on any studies. I see the potential for collaboration much like the synergy that exists between physical therapy and orthopedic surgery. I really didn't fully grasp what occurs in vision therapy until I visited Dr. Torgerson's office, so sometimes we have to step outside our comfort zone. She has a grounded approach and definitive endpoints in therapy, something that I do not always encounter with other practitioners.

Dr. Torgerson: As Dr. Lenart but in the inverse, I have encountered pediatric ophthalmologists with whom I would feel comfortable establishing a collaborative relationship. Neither of our professions really exposes doctors in training to collaboration of this nature; so, finding common ground is left to chance. That really is unfortunate, and one of our goals is to spread awareness of our success. We recently gave a presentation on this at the SECO Conference, one of the largest continuing education venues in optometry. We will be doing a joint presentation at the upcoming COVD meeting, which will be heard by close to 500 optometrists. Now, the key question is will ophthalmology meetings begin to welcome collaboration of this nature?

Dr. Press: What advice would you give to those reading this who may want to emulate the collaborative relationship you've established?

Dr. Lenart: Look at the large-scale studies that are out there. Take the PEDIG (Pediatric Eye Disease Investigator Group) studies, for example, that represent NEI-funded collaboratives between our two professions. Regarding occlusion treatment of amblyopia, we operated under the dogma of "full-time to gain, part-time to maintain." We have to keep an open mind to trying new things and to learning. Now we can confidently manage amblyopia through the patching management and the approach vision therapy has been doing for years. This involves part-time patching with active near work in the appropriate patient population. I am constantly expanding my horizons based on the successes that I see through vision therapy.

Dr. Torgerson: Agreed! The CITT (Convergence Insufficiency Treatment Trials) studies are another great example. They've shown that office-based vision therapy combined with home therapy is incomparably better than therapy done solely at home. I would have expected that both of our professions would have embraced this by now; however, even though this is gold-standard, evidence-based medicine, its adoption has been slow. That is where the flexibility of bringing the best of what each of our professions has to offer can be most effective, case by case with interactions in our practices.

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