801st

meeting of the

New England Ophthalmological Society

AM Session:

CATARACT SURGERY IN NEW ENGLAND: WHAT IS NEW, WHAT IS NEXT (with Hal M. Freeman Lecture)

Moderator: William Gensheimer, MD / PC Coordinator: JoAnn Chang, MD
Guest of Honor: Kendall E. Donaldson, MD, MS (Bascom Palmer, Plantation, FL)

PM Session:

CLINICAL INSIGHTS INTO PEDIATRIC ANTERIOR SEGMENT DISORDERS AND THEIR IMPACT ON ADULTHOOD

Moderator: Bharti K. Gangwani, MD / PC Coordinator: Gena Heidary, MD, PhD
Guest of Honor: Scott R. Lambert, MD (Stanford Medicine, Palo Alto, CA)

NEOS ANNUAL MEETING FOR TECHNICIANS AND NURSES (all day)

FRIDAY, September 19, 2025
Boston Marriott Copley Place
110 Huntington Ave, Boston, MA

New England Ophthalmological Society
860 Winter St., Waltham, MA 02451
www.neos-eyes.org | neos-eyes@mms.org | 781-434-7656
@NEOS_Eyes

The 801st Meeting of

The New England Ophthalmological Society, Inc.

A Public Foundation for Education in Ophthalmology

FRIDAY, SEPTEMBER 19, 2025 | **BOSTON MARRIOTT COPLEY PLACE**
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AMA Credit Designation Statement

The New England Ophthalmological Society designates this live activity for a maximum of:
AM Session: 4.0 *AMA PRA Category 1 Credits™*
PM Session: 2.5 *AMA PRA Category 1 Credits™*
"Physicians should claim only the credit commensurate with the extent of their participation in the activity."

Accreditation Statement

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for continuing Medical Education. The New England Ophthalmological Society is accredited by the Massachusetts Medical Society to provide continuing medical education for physicians.

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PRESIDENT'S MESSAGE

Angela Turalba, MD, MMS

It is a privilege to serve as the New England Ophthalmological Society (NEOS) president for 2025-26, and I look forward to connecting with you at our meetings throughout the year. As one of the oldest medical specialty societies in the United States, NEOS remains a unique resource and venue for ophthalmologists across New England. In the spirit of the organization's mission to serve and provide educational forums for ophthalmologists across the region, we strive to keep NEOS relevant to new and seasoned physicians from a variety of practice settings.

We will kick off this year with the **801st** meeting of NEOS, in conjunction with the 35th Annual Meeting for Ophthalmic Medical Personnel. Our Program Committee led by Dr. Fina Barouch tirelessly organizes well thought-out educational programs throughout the year to cater to generalists and specialists alike. We purposefully engage trainees with our Grand Rounds, as well as the annual Poster competition. This year we are expanding our educational format by offering a Neuro-ophthalmology webinar in November where fellows in training and a panel of specialists will present and discuss clinical cases. By providing several venues for our younger colleagues to interact with more established peers, NEOS continues to foster an invaluable community and network for ophthalmologists in New England.

A special addition to this year's programming will be the NEOS 800th Meeting Gala on December 5, 2025 celebrating the 800th NEOS meeting held last Spring. Proceeds from this exciting fundraising event will support the NEOS Education Endowment Fund which supports our Society's mission of lifelong learning and member engagement. The Gala will also celebrate the Michael Bradbury Named Lectureship created to honor all past and present NEOS Executive Directors. Like those before him, Dr. Bradbury is an indispensable figure in the Society, whose work and dedication ensures a strong foundation for NEOS. I expect the Gala to be an exciting event with the strong leadership of Dr. Jorge Arroyo and the Gala Subcommittee (Drs. Astrid Werner, Michelle Liang, and Kendra Klein). It will be a wonderful opportunity to celebrate the Society's history and achievements while laying important groundwork for continued success and vitality.

I must acknowledge our Executive Administrator, Miguel Ocque, our volunteer Board, and Committee members for their hard work and service to NEOS members and our community. I'd also like to thank our industry sponsors who support NEOS and our educational programs. It truly is an honor to be part of this vibrant Society, and I am eager to see NEOS flourish in the years to come.

Angela Turalba, MD, MMS

President

800 JUBILEE GALA

Dear NEOS Members and Friends,

Join us for the NEOS 800th Meeting Gala, a historic celebration marking over a century of excellence in ophthalmology!

Date: Friday, December 5, 2025

Location: The Commonwealth Hotel, Kenmore Square, Boston

Don't miss an unforgettable evening filled with celebration, history, live music, and the warmth of our vibrant community. This milestone event is a once-in-a-century occasion—miss it, and you'll have to wait another 100 meetings for the next centennial gala!

Registration and sponsorship opportunities are available on our website at **www.neos-eyes.org**

We can't wait to celebrate with you!

GUEST OF HONOR AND HAL M. FREEMAN LECTURER

Kendall E. Donaldson, MD, MS

Kendall E. Donaldson, MD, MS, is a distinguished cornea specialist and Professor of Clinical Ophthalmology at the Bascom Palmer Eye Institute, where she has served as the Medical Director of the Plantation location since 2004. She holds the Rodgers Clark Chair in Ophthalmology and specializes in cataracts and intraocular lens, corneal diseases, LASIK, laser vision correction, and ocular surface reconstruction. Dr. Donaldson's research focuses on advancements in cataract and refractive surgery, particularly laser-assisted techniques, and severe ocular surface diseases.

A leader in her field, she has authored numerous peer-reviewed articles, book chapters, and founded Corneal Physician journal and its virtual symposium. She co-directs the ASCRS refractive surgery certificate program (20/Happy) and serves as chairman of the ASCRS Refractive Subcommittee. Recognized on The Ophthalmologist Power List 2021, Dr. Donaldson is celebrated for her expertise, compassion, and commitment to patient care, delivering over 150 lectures annually on local, national, and international stages.

THE HAL M. FREEMAN LECTURE

Hal Mackenzie Freeman, MD, a pioneer and legendary figure in Ophthalmology, was born on March 25th, 1929, and died on March 14th, 2018, at the age of 88. He conducted his undergraduate studies and earned his medical degree at the University of Alberta and the University of British Columbia. After residency at the Illinois Eye and Ear Infirmary, Dr. Freeman trained in Retina at the Massachusetts Eye and Ear Infirmary and the Retina Foundation in Boston. He soon became a leading force in surgery of complex vitreoretinal diseases, including the dreaded and formerly hopeless giant retinal tears. His many contributions led to increasing success in giant retinal tear surgery, as well as advanced vitreoretinal diseases. Dr. Freeman was a truly legendary figure in ophthalmology.

As a regional, national, and internationally invited speaker he was widely sought. His crisp style was renown with "no more than 5 lines on a slide" and each major point clearly implanted in the audience. He was lecturer in 185 courses and was invited to be a guest speaker in 300 symposia in nearly every major country of the world. He authored 6 books, 120 original reports, 49 book chapters, and many other writing endeavors, yet he found time to serve as a preceptor to 175 retinal fellows. He received innumerable honors including those by The Retina Society, the Canadian Ophthalmological Society, the Wilmer Eye Institute, the American Academy of Ophthalmology, the Brazilian and Japanese Ophthalmological Societies.

Serving in numerous leadership positions in professional organizations, Dr. Freeman was the past president of the Retina Society, the Schepens International Society, and the New England Ophthalmological Society (NEOS); for the American Academy of Ophthalmology (AAO), he was the past associate secretary of governmental affairs and the first associate secretary for subspecialty day.

As a leader of the NEOS, Dr. Freeman served with grace and excellence in his positions as secretary, vice president, president, and executive director. He was creative, energetic, and above all, a modest leader.

Ophthalmologists and patients around the world will always remember Dr. Freeman with the greatest respect and affection. At NEOS, we are grateful to be able to honor Dr. Freeman and continue to celebrate his legacy through the Hal M. Freeman Lecture for the years to come.

Previous Hal M. Freeman lecturers:

2025 - Benjamin Bakall, MD, PhD | 2024 – Brandon Ayres, MD
2023 – Donald J. D'Amico, MD | 2022 – Esen K. Akpek, MD

GUEST OF HONOR

Scott R. Lambert, MD

Scott R. Lambert, M.D., is a Professor of Ophthalmology and Pediatrics who specializes in treating eye diseases in children and adults with strabismus. Prior to joining the faculty at Stanford in 2016, he was the R. Howard Dobbs Professor of Ophthalmology at Emory University and the Chief of Ophthalmology at Children's Healthcare of Atlanta. Dr. Lambert graduated from medical school at Yale University and completed a residency in ophthalmology at the University of California, San Francisco. He then completed a fellowship in pediatric ophthalmology at the Hospital for Sick Children in London and in adult strabismus in San Francisco.

Dr. Lambert is the co-editor of the 5th and 6th edition of the leading textbook in his field--Pediatric Ophthalmology and Strabismus. He is the author or co-author of more than 260 articles in peer-reviewed journals on a broad range of topics including the treatment of congenital cataracts, strabismus in adults and children, optic disc abnormalities and corneal disorders in children. He has been an invited speaker at pediatric ophthalmology conferences throughout the world including North America, South America, Europe, Asia, Africa, the Middle East and Australia.

Dr. Lambert has been actively involved in research throughout his entire career and served as the chairman of the Infant Aphakia Treatment Study—a NIH funded randomized clinical trial comparing the optical treatment of infants after cataract surgery with contact lenses vs. intraocular lenses. From 2013-2015 he served on the executive committee of the Pediatric Eye Disease Investigators Group--a large group of pediatric ophthalmologists who investigate new treatments for ocular disorders in children. He has received the Senior Honor award from the American Academy of Ophthalmology and served as the chairman of their Pediatric Ophthalmic Technology Assessment Committee. He has received a lifetime achievement award from the American Association for Pediatric Ophthalmology and Strabismus.

Dr. Lambert has five children. He enjoys hiking, swimming, and running.

AM SESSION

Room: "Salon F" (4th fl.)

CATARACT SURGERY IN NEW ENGLAND: WHAT IS NEW, WHAT IS NEXT

Moderator: William Gensheimer, MD / PC Coordinator: JoAnn Chang, MD

Program Objectives: The content and format of this educational activity has been specifically designed to fill the practice gaps in the audience's current potential scope of professional activities by:

1. Reviewing recent technological advances in cataract surgery and discussing anticipated future developments in cataract surgery technology and techniques.
2. Learning new and innovative surgical techniques that can be utilized in complex or complicated cataract surgery cases through surgical videos.
3. Discussing tips for pre-operative planning to ensure surgical success.

7:15 am	Registration / Exhibits / Continental Breakfast
7:30	**NEOS Grand Rounds (presented by BU)**
8:30	Introduction of Session..... William Gensheimer, MD
8:35	**Maine – Lobster Traps:** IOL Calculations for Post-refractive Eyes.....Mina Farahani, MD
8:45	**New Hampshire – Mount Washington:** Management of Posterior Capsule Rupture and IOL placement with Poor Capsule Support..... Naveen Rao, MD
8:55	**New Hampshire – Live Free or Die:** IOL Exchanges for the Unhappy Patient.....Jeremy Kieval, MD
9:05	**Vermont – Ski the East:** How to Avoid "Tilting Over" in the Crud and Ice.... Amal Alwreikat, MD
9:15	Introduction of the Guest of Honor ..... William Gensheimer, MD
9:20	**Massachusetts – Boston Tea Party:** Video Review of Technology and Techniques... Kendall E. Donaldson, MD
9:45	Q&A, Panel Discussion .....Moderator: William Gensheimer, MD ***Panelists:*** Amal Alwreikat, MD .....Jeremy Kieval, MD Kendall E. Donaldson, MD..... Naveen Rao, MD Mina Farahani, MD
10:00	**Refreshments / Exhibits**

10:30	**Vermont – Maple Syrup:** Is Scleral Fixation with Gore-Tex Sweeter than Yamane? ..... Nikhil Bommakanti, MD
10:40	**Connecticut – Nutmeg State:** How to Be Ingenious and Shrewd in Cases of Zonulopathy ..... Helen Wu, MD
10:50	**Rhode Island – Sailing:** Patient Selection for Extended Depth of focus (EDOF), Multifocal, and Light Adjustable IOLs. ..... Jason Brenner, MD
11:00	Introduction of **Hal M. Freeman Lecture** .... Michael Bradbury, MD
11:05	**Innovation and Technology:** What Will Be the Greatest Advances in Cataract Surgery Over the Next 5 Years? ..... Kendall E. Donaldson, MD
11:35	**Q&A, Panel Discussion** ..... *Moderator:* William Gensheimer, MD
	Panelists: Nikhil Bommakanti, MD ..... Kendall E. Donaldson, MD Jason Brenner, MD ..... Helen Wu, MD
11:50	**NEOS Business Meeting**
12:00 pm	**Lunch** *(included for all attendees)*
1:00 – 4:00	**Afternoon Session** (Clinical Insights into Pediatric Anterior Segment Disorders and their Impact on Adulthood) – see next page
4:00 pm	**NEOS Social Hour / Cocktail**

BE SURE TO SCAN IN AT REGISTRATION
DESK FOR AFTERNOON SESSION
TO RECEIVE EVALUATION/CREDIT

PM SESSION

Room: "Salon F" (4th fl.)

CLINICAL INSIGHTS INTO PEDIATRIC ANTERIOR SEGMENT DISORDERS AND THEIR IMPACT ON ADULTHOOD

Moderator: Bharti K. Gangwani, MD / PC Coordinator: Gena Heidary, MD, PhD

Program Objectives: The content and format of this educational activity has been specifically designed to fill the practice gaps in the audience's current potential scope of professional activities by:

1. Describing updated diagnostic and management approaches to pediatric anterior segment disorders
2. Highlighting management challenges in pediatric population
3. Explaining the impact of pediatric disorders on adulthood

1:00 pm	Introduction of Session ..... Bharti K. Gangwani, MD
1:05	Current Management of Pediatric Cataracts ..... Lindsay Imber, MD
1:15	IOL Power Calculation and Refractive Challenges in Pediatric eyes ..... Jill Rotruck, MD
1:25	Secondary IOL implantation – When and how? ..... Deborah K. VanderVeen, MD
1:35	Introduction GOH ..... Bharti Gangwani, MD
1:40	Glaucoma Following Pediatric Cataract Surgery ..... Scott R. Lambert, MD
2:00	Updates on Congenital Glaucoma ..... Daniel M. Vu, MD
2:10	Unveiling the Mystery Behind Red Eyes ..... Erin M. Salcone, MD
2:20	Refreshments / Exhibits
2:50	Pediatric Corneal Disorders and Their Impact on Adulthood ..... Thomas H. Dohlman, MD
3:00	A New Era in Management of Pediatric Uveitis ..... Danielle Ledoux, MD
3:10	Best Practices for Pediatric Cataract Surgery ..... Scott R. Lambert, MD
3:30	Anterior Segment Imaging for Pediatric Anterior Segment Disorders ..... Ankoor Shah, MD

3:40	**Q&A, Panel Discussion** ..... Moderator: Bharti K. Gangwani, MD
	Panelists:
	Thomas H. Dohlman, MD ..... Jill Rotruck, MD
	Lindsay Imber, MD ..... Erin M. Salcone, MD
	Scott R. Lambert, MD ..... Ankoor Shah, MD
	Danielle Ledoux, MD ..... Daniel M. Vu, MD
4:00 pm	Adjourn. NEOS Social Hour / Cocktail

IOL CALCULATIONS IN POST- REFRACTIVE EYES

Mina Farahani, MD

SPINDEL EYE ASSOCIATES, DERRY, NH

Objective:

This presentation will discuss the clinical importance and challenge of ensuring accurate biometry after refractive surgery. Steps to mitigate this complexity and ensure you hit your refractive target will be reviewed.

IOL power calculation in post-refractive surgery eyes continues to pose a significant challenge for cataract surgeons due to disrupted corneal biomechanics and inaccurate assumptions in traditional biometric formulas. This presentation distills the latest evidence and best practices for IOL selection in eyes with prior myopic or hyperopic LASIK, PRK, or radial keratotomy. We will explore the key sources of errors, particularly ELP estimation and altered keratometry, and evaluate the performance of contemporary no-history formulas such as Barrett True-K, Haigis-L, and the Shammas method. Emphasis will be placed on the integration of advanced diagnostics, including Scheimpflug imaging and swept-source OCT, and the role of intraoperative aberrometry and ray-tracing. Additionally, we'll highlight emerging AI-driven tools and their clinical relevance. The clinical role of light adjustable lens technology in complex post refractive surgery cases will also be discussed. The session concludes with practical, case-based recommendations for minimizing refractive surprises and enhancing outcomes in this growing subset of patients.

References:

1. The Prevalence of Demodex Blepharitis in US Eye Care Clinic Patients as Determined by Collarettes: A Pathognomonic Sign. Clinical Ophthalmology 2022:16 1153–1164.

2. Detection of Subclinical Neurotrophic Keratopathy by Noncontact Esthesiometry. Ophthalmol Ther (2024) 13:2393–2404.

3. Management of Glaucoma-Related Dry Eye Disease with Intense Pulsed Light: A Randomized Control Study. Clinical Ophthalmology 2024:18 2061–2072.

MANAGEMENT OF POSTERIOR CAPSULE RUPTURE AND IOL PLACEMENT WITH POOR CAPSULE SUPPORT

Naveen Rao, MD

OPHTHALMIC CONSULTANTS OF BOSTON, BOSTON, MA

Objective:

1. To review key steps for intraoperative management of posterior capsule rupture.

2. To discuss the pros and cons of various options for IOL placement in the setting of poor capsule support.

When the capsule ruptures during cataract surgery, we can all agree that if vitreous prolapses forward, the first step is to perform a vitrectomy. But what should be done next? There is no consensus on the optimal IOL implantation technique in the absence of adequate capsular support (as seen with ocular trauma or severe pseudoexfoliation), when an IOL cannot be safely placed within the capsular bag or in the sulcus. There are numerous options, including ACIOL placement, iris-fixation, and scleral-fixation, each of which has distinct advantages and challenges. This talk will briefly cover some pitfalls of using ACIOLs, including malposition, irregular astigmatism, corneal decompensation, and cystoid macular edema. Iris-sutured and scleral-sutured IOL fixation techniques will then be reviewed, including the glued IOL and Yamane techniques.

References:

1. Yamane S, Sato S, Maruyama-Inoue M, Kadonosono K. Flanged Intrascleral Intraocular Lens Fixation with Double-Needle Technique. Ophthalmology. 2017;124(8):1136-1142.

2. Gabor SG, Pavlidis MM. Sutureless intrascleral posterior chamber intraocular lens fixation. J Cataract Refract Surg. 2007;33(11):1851-4.

3. Agarwal A, Kumar DA, Jacob S, Baid C, Agarwal A, Srinivasan S. Fibrin glue-assisted sutureless posterior chamber intraocular lens implantation in eyes with deficient posterior capsules. J Cataract Refract Surg. 2008;34(9):1433-8.

10:30 AM

IS SCLERAL FIXATION WITH GORE-TEX SWEETER THAN YAMANE?

Nikhil Bommakanti, MD

TUFTS MEDICAL CENTER, NEW ENGLAND EYE CENTER, BOSTON, MA

Objective:

To discuss tips for IOL scleral fixation using Gore-Tex suture.

There are many ways to fixate an intraocular lens when capsular or sulcus support is absent, but there isn't a single best approach. The optimal choice depends on the case, patient factors, and the surgeon's comfort level. Gore-Tex suture fixation can be a good option because the surgery tends to be more consistent, and the lens is less likely to end up decentered or tilted. I will share my approach to Gore-Tex suture fixation, along with practical tips for the key steps of the surgery.

References:

Shen JF, Deng S, Hammersmith KM, et al. Intraocular lens implantation in the absence of zonular support: an outcomes and safety update: a report by the American Academy of Ophthalmology. Ophthalmology. 2020;127(9):1234-1258. doi:10.1016/j.ophtha.2020.03.005 Kaufmann GT, Gupta O, Yu J, et al. Vitreoretinal outcomes following secondary intraocular lens implantation with pars plana vitrectomy. Retina. 2024;44(8):1337-1343. doi:10.1097/IAE.0000000000004139 https://www.reviewofophthalmology.com/article/secondary-iol-best-practices

CURRENT MANAGEMENT OF PEDIATRIC CATARACTS

Lindsay Imber, MD

OPHTHALMIC CONSULTANTS OF BOSTON, BOSTON, MA

Objective:

This presentation is an overview of the current best practices in the management of pediatric cataracts based on the literature.

Pediatric cataracts remain a major cause of preventable visual impairment, requiring early recognition and individualized care to optimize outcomes. Advances in surgical techniques, intraocular lenses, and amblyopia treatment have improved the prognosis for affected children. Pediatric cataract management, however, continues to pose unique challenges, both technical and functional, compared to adult cataract care.

This presentation is an overview of the current best practices in the management of pediatric cataracts based on the literature. Initial evaluation of pediatric cataracts must assess for underlying non-ophthalmic pathology, as bilateral cataracts are more frequently associated with metabolic, genetic, or systemic abnormalities. Intervention is dependent on lens morphology and whether it is visually significant. If determined to be visually significant, surgical intervention must be performed without delay to maximize visual development. The timing of when to perform surgery is dictated by the "critical period," as described by Birch et al. This critical period for unilateral congenital nuclear or total cataracts is 4-6 weeks, and for bilateral congenital nuclear or total cataracts it is 2-3 months. A major decision in surgical planning is whether to place an intraocular lens or to leave the patient aphakic, a decision which weighs the benefits of optimal optical correction with potential adverse events.

Equally critical to the timing and approach to surgery is the postoperative management of pediatric cataracts. This includes optical correction with aphakic contact lenses, glasses, or secondary IOLs, as well as postoperative amblyopia therapy, and prevention of visual axis opacification.

By integrating evidence from recent trials and international guidelines, this session will provide ophthalmologists with an up-to-date overview of the current management of pediatric cataracts.

References:

1. Lenhart PD, Lambert SR. Current management of infantile cataracts. Surv Ophthalmol. 2022 Sep-Oct;67(5):1476-1505. doi: 10.1016/j.survophthal.2022.03.005. Epub 2022 Mar 17. PMID: 35307324; PMCID: PMC10199332.

2. Lenhart PD, Lambert SR. Current management of infantile cataracts. Surv Ophthalmol. 2022 Sep-Oct;67(5):1476-1505. doi: 10.1016/j.survophthal.2022.03.005. Epub 2022 Mar 17. PMID: 35307324; PMCID: PMC10199332.

3. Lambert SR, Aakalu VK, Hutchinson AK, Pineles SL, Galvin JA, Heidary G, Binenbaum G, VanderVeen DK. Intraocular Lens Implantation during Early Childhood: A Report by the American Academy of Ophthalmology. Ophthalmology. 2019 Oct;126(10):1454-1461. doi: 10.1016/j.ophtha.2019.05.009. Epub 2019 Jun 21. PMID: 31230794.

1:15 PM

IOL POWER CALCULATION AND REFRACTIVE CHALLENGES IN PEDIATRIC EYES

Jill Rotruck, MD

YALE SCHOOL OF MEDICINE, NEW HAVEN, CT

Objective:

To review refractive target selection, IOL power calculation formula selection, and biometry measurements in pediatric patients.

Selecting an intraocular lens (IOL) for implantation in children is complicated by significant changes in axial length, keratometry, and refractive status early in life. Refractive targets in children should account for the anticipated shift toward myopia over time. Newer generation IOL formulas have relatively lower predictive error compared to older generation formulas, but very short eyes (≤21 mm) remain difficult to predict. Accurate biometry is essential for achieving refractive targets, yet it can be challenging to obtain because of limited cooperation in awake children and the inability of the patient to fixate to ensure proper visual axis alignment under anesthesia. Families should be counselled regarding the possibility of refractive surprises, the need for refractive correction in patients who are left hyperopic, the unpredictable nature of refractive shifts in children, and the possibility of a future intraocular lens implant exchange.

References:

1) VanderVeen DK, Oke I, Nihalani BR. Deviations From Age-Adjusted Normative Biometry Measures in Children Undergoing Cataract Surgery: Implications for Postoperative Target Refraction and IOL Power Selection. Am J Ophthalmol. 2022 Jul;239:190-201. doi: 10.1016/j.ajo.2022.02.022. Epub 2022 Mar 10. PMID: 35278359. 2) Lin L, Fang J, Sun W, Gu S, Xu L, Chen S, Chang P, Zhao YE. Accuracy of newer generation intraocular lens power calculation formulas in pediatric cataract patients. Graefes Arch Clin Exp Ophthalmol. 2023 Apr;261(4):1019-1027. doi: 10.1007/s00417-022-05896-z. Epub 2022 Nov 17. PMID: 36385570. 3) Rathod A, Khokhar S, Rani D. Pediatric IOL power calculation: Factors and considerations. Indian J Ophthalmol. 2025 Mar 1;73(3):312-319. doi: 10.4103/IJO.IJO_1205_24. Epub 2025 Feb 26. PMID: 40007266; PMCID: PMC11994192.

1:25 PM

SECONDARY IOLS IN CHILDREN: WHEN AND HOW

Deborah K. VanderVeen, MD

BOSTON CHILDREN'S HOSPITAL, BOSTON, MA

Objective:

To review indications and current techniques for secondary IOL implantation in children

Children who are left aphakic after lensectomy may benefit from IOL implantation at a later date. If there is good visual potential and the eye is healthy, IOL implantation surgery may be planned in cases of necessity (for intolerance of other modes of refractive correction), or as an elective procedure. Current techniques for implantation will be reviewed. While IOL placement within the capsular bag or ciliary sulcus are most common, other techniques will be referenced, as well as clinically relevant outcomes in pediatric cohorts.

References:

Nihalani BR, VanderVeen DK. Long-term outcomes of secondary intraocular lens implantation in children. Graefes Arch Clin Exp Ophthalmol. 2022 May;260(5):1733-1739. Hayes WG, Wilson ME, Trivedi RH. Predictors of early secondary IOL implantation after pediatric cataract surgery. J AAPOS. 2024 Aug;28(4):103965. Epub 2024 Jul 3. Wang S, Repka MX, Sutherland DR, Hatt SR, Traboulsi EI, Lambert SR, Melia BM, Kraker RT, Holmes JM, Cotter SA; Pediatric Eye Disease Investigator Group. Complications, Visual Acuity, and Refractive Error 3 Years after Secondary Intraocular Lens Implantation for Pediatric Aphakia. Ophthalmology. 2024 Oct;131(10):1196-1206.

GLAUCOMA FOLLOWING PEDIATRIC CATARACT SURGERY

Scott Lambert, MD

STANFORD UNIVERSITY, PALO ALTO, CA

Objective:

To identify and characterize incident cases of glaucoma and glaucoma-related adverse events (glaucoma + glaucoma suspect) among children in the Infant Aphakia Treatment Study (IATS) by the age of 10.5 years and to determine whether these diagnoses are associated with optic nerve head (ONH) and peripapillary retinal nerve fiber layer (RNFL) assessment.

Importance: Glaucoma-related adverse events constitute serious complications of cataract removal in infancy, yet long-term data on incidence and visual outcome remain lacking.

Design, setting, and participants: Analysis of a multicenter randomized clinical trial of 114 infants with unilateral congenital cataract who were aged 1 to 6 months at surgery. Data on long-term glaucoma-related status and outcomes were collected when children were 10.5 years old (July 14, 2015, to July 12, 2019) and analyzed from March 30, 2019, to August 6, 2019.

Interventions: Participants were randomized at cataract surgery to either primary intraocular lens (IOL), or aphakia (contact lens [CL]). Standardized definitions of glaucoma and glaucoma suspect were created for IATS and applied for surveillance and diagnosis.

Main outcomes and measures: Development of glaucoma and glaucoma + glaucoma suspect in operated-on eyes up to age 10.5 years, plus intraocular pressure, axial length, RNFL (by optical coherence tomography), and ONH photographs.

Results: In Kaplan-Meier analysis, for all study eyes combined (n = 114), risk of glaucoma after cataract removal rose from 9% (95% CI, 5%-16%) at 1 year, to 17% (95% CI, 11%-25%) at 5 years, to 22% (95% CI, 16%-31%) at 10 years. The risk of glaucoma plus glaucoma suspect diagnosis after cataract removal rose from 12% (95% CI, 7%-20%) at 1 year, to 31% (95% CI, 24%-41%) at 5 years, to 40% (95% CI, 32%-50%) at 10 years. Risk of glaucoma and glaucoma plus glaucoma suspect diagnosis at 10 years was not significantly different between treatment groups. Eyes with glaucoma (compared with eyes with glaucoma suspect or neither) had longer axial length but relatively preserved RNFL and similar ONH appearance and visual acuity at age 10 years.

Conclusions and relevance: Risk of glaucoma-related adverse events continues to increase with longer follow-up of children following unilateral cataract removal in infancy and is not associated with primary IOL implantation. Development of glaucoma (or glaucoma suspect) after removal of unilateral congenital cataract was not associated with worse visual acuity outcomes at 10 years.

References:

1. Asrani S, Freedman S, Hasselblad V, et al. Does primary intraocular lens implantation prevent "aphakic" glaucoma in children? J AAPOS. 2000;4(1):33-39.

2. Mataftsi A, Haidich AB, Kokkali S, Rabiah PK, Birch E, Stager DK Jr, Cheong-Leen R, Singh V, Egbert JE, Astle WF, Lambert SR, Amitabh P, Khan AO, Grigg J, Arvanitidou M, Dimitrakos SA, Nischal KK. Postoperative glaucoma following infantile cataract surgery: an individual patient data meta-analysis. JAMA Ophthalmol 2014;132:1059-1067.

3. Freedman SF, Beck AD, Nizam A, Vanderveen DK, Plager DA, Morrison DG, Drews-Botsch CD, Lambert SR for The Infant Aphakia Treatment Study Group. Glaucoma-related adverse events at 10 years in the Infant Aphakia Treatment Study: a randomized clinical trial. JAMA Ophthalmol 2021;139:165-173.

UPDATES ON CONGENITAL GLAUCOMA

Daniel Vu, MD

MASSACHUSETTS EYE AND EAR, BOSTON, MA

Objective:

To learn about the international classification system for childhood glaucoma diagnosis, recent advances in the genetics of primary congenital glaucoma, and techniques for 360-degree angle surgery.

Congenital glaucoma encompasses a group of potentially sight-threatening conditions typically presenting with elevated intraocular pressure, buphthalmos, breaks in Descemet's membrane, and axial elongation. The World Glaucoma Association has developed an international classification system that organizes childhood glaucoma into six categories, including primary congenital glaucoma (PCG). To date, three gene mutations, *CYP1B1*, *LTBP2*, and *TEK*, have been identified in association with PCG. Current evidence suggests that 360-degree angle surgeries offer higher success rates for PCG than more limited procedures.

References:

Weinreb RN, Grajewski A, Papadopoulos M, Grigg J, Freedman S. Childhood Glaucoma: The 9th Consensus Report of the World Glaucoma Association. Amsterdam: Kugler Publications; 2013. Souma T, Tompson SW, Thomson BR, et al. Angiopoietin receptor TEK mutations underlie primary congenital glaucoma with variable expressivity. J Clin Invest. 2016;126(7):2575-87. Berger O, Mohamed-Noriega J, Low S, et al. From Conventional Angle Surgery to 360-Degree Trabeculotomy in Pediatric Glaucoma. Am J Ophthalmol. 2020;219:77-86.

2:10 PM

UNVEILING THE MYSTERY BEHIND RED EYES

Erin Salcone, MD

DARTMOUTH HITCHCOCK MEDICAL CENTER, LEBANON, NH

Objective:

To discuss common diagnoses and management of a red eye in childhood.

The red eye is a common presentation for pediatric patients in the eye clinic and offers unique challenges for the clinician. Diagnosis, management, and follow up can be quite tricky! However, the long-term consequences of inadequate treatment can be visually devastating. The objective of this talk is to provide tips to approach a child with a red eye, develop a differential diagnosis, and discuss in more detail treatment strategies for the most common and debilitating condition causing red eye in childhood – blepharokeratoconjunctivitis. This chronic and recurrent condition can frustrate families and providers and result in permanent ocular surface scarring, refractive changes, and amblyopia. Current understandings of the pathophysiology and a tiered approach to management is reviewed.

References:

Ortiz-Morales et al, Pediatric blepharokeratoconjunctivitis: A challenging ocular surface disease. Surv Ophthalmol. 2025 May-Jun;70(3):516-535 Sari et al. Long-term, low-dose oral azithromycin treatment for chronic severe bilateral blepharokeratoconjunctivitis in pediatric patients. J Pediatr Ophthalmol Strabismus. 2024 Sep-Oct;61(5):358-364. Wong, Anninger. The pediatric red eye. Pediatr Clin North Am. 2014 June;61(3):591-606.

A NEW ERA IN THE MANAGEMENT OF PEDIATRIC UVEITIS

Danielle Ledoux, MD

SPECIALIZED PEDIATRIC EYE CARE, INC., BEVERLY, MA

Objective:

Pediatric Uveitis is a vision threatening condition that frequently requires systemic therapy to achieve quiescence. Therapies have drastically changed over the last two decades so the aim of this talk is to inform ophthalmologists on how to successfully manage these patients with the available treatment options.

Purpose/Relevance: Ophthalmologists care for patients of all ages with uveitis. Pediatric Uveitis poses specific risks, and their care will differ from adult management.

Target Audience: Ophthalmologists who care for pediatric patients and would benefit from an update in current therapeutic options in pediatric uveitis care.

Expected Outcomes: Care for the pediatric uveitis patient involves a stepwise treatment ladder approach. Many of the immunomodulatory (IMT) drugs on the higher rungs of this ladder are new over the past two decades. Ophthalmologists that attend will feel comfortable in managing these complicated uveitis patients and feel empowered to adequately treat their uveitis and reduce ocular complications and poor visual outcomes.

Summary: Improvement in uveitis management for the pediatric patient can be expected with a more thorough understanding of the current therapeutic options and the latest studies addressing improved outcomes in management.

References:

1.) Ann Rheum Dis. 2018 Mar 28;77(8):1107–1117. Consensus-based recommendations for the management of uveitis associated with juvenile idiopathic arthritis: the SHARE initiative 2.)Arthritis Care Res. 2019 Apr;71(4):482-491Childhood Arthritis and Rheumatology Research Alliance Consensus Treatment Plans for Juvenile Idiopathic Arthritis-Associated and Idiopathic Chronic Anterior Uveitis 3.)Arthritis Care Res 2019 Jun;71(6):703-716. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Screening, Monitoring, and Treatment of Juvenile Idiopathic Arthritis-Associated Uveitis

3:10 PM

BEST PRACTICES FOR PEDIATRIC CATARACT SURGERY

Scott Lambert, MD

STANFORD UNIVERSITY, PALO ALTO, CA

Objective:

To provide an update on pediatric cataract surgery based on findings from randomized clinical trials.

Infantile cataracts remain one of the most treatable causes of lifelong visual impairment. While the chance of improving vision for children with infantile cataracts has never been better, significant global and socioeconomic disparities still exist in their early management. Recent epidemiological studies reveal a stable prevalence of infantile cataracts in high-income countries and highlight challenges in determining the prevalence of infantile cataracts in low-income countries. Detailed descriptions of cataract morphology may inform us as to etiology, provide guidance with regards to surgical approach, and have prognostic value. Molecular genetics is providing new insights into the hereditary bases and potential systemic associations of infantile cataracts. For visually significant infantile cataracts requiring surgery to clear the visual axis, surgical techniques continue to evolve based on the experiences and research efforts of skilled teams worldwide. The most common complications of cataract surgery performed in infancy are visual axis opacification and, in about a third of patients, the long-term development of glaucoma. Children with unilateral cataracts generally see well given the presence of a healthy fellow eye. Better visual outcomes in operated eyes, however, are achieved in the setting of early presentation, bilateral infantile cataracts, absence of nystagmus or strabismus, and consistent amblyopia therapy. While intraocular lenses for infants less than 6 months can result in good visual outcomes, contact lenses may be preferred in situations in which they are available and practical. Many studies have demonstrated the benefits of early surgery for infantile cataract. We must strive for the continued evolution of technologies and strategies that have the potential to further improve these outcomes.

References:

1. Lenhart PD, Lambert SR. Current Management of Infantile Cataracts. Surv Ophthalmol. 2022;67:1476-1505.

2. Lloyd IC, Wilson ME, Trivedi RH, Biswas S, Ashworth JL, Green E, Self J, Voltz K, Archambault C, McClatchey TS, McClatchey SK, Randeree J, Gowing J, Cowen S, Barker L, Kekunnaya R, Lambert SR. Update on Pediatric Cataract Surgery. Asia Pac J Ophthalmol 2025 Jul-Aug;14(4):100229.

3:30 PM

ANTERIOR SEGMENT IMAGING OF PEDIATRIC EYE DISORDERS

Ankoor Shah, MD, PhD

BOSTON CHILDREN'S HOSPITAL, BOSTON, MA

Objective:

To review modalities of anterior segment imaging that may help visualize, diagnose, and manage pediatric eye disorders.

Anterior segment imaging techniques may help visualize, diagnose, and manage pediatric eye disorders. This talk will review techniques for obtaining anterior segment photography, ultrasound biomicroscopy, anterior segment optical coherence tomography, and corneal topography. Interleaved case examples of each imaging modality capturing anterior segment pathology will be shown with a discussion of its utility in clinical and surgical practice as well as its benefits in the education of patients and medical professionals.

References:

1. Xiang, D., Chen, L., Hu, L., Song, S., Xie, W., Long, J., 2016. Image features of lens opacity in pediatric cataracts using ultrasound biomicroscopy. Journal of American Association for Pediatric Ophthalmology and Strabismus 20, 519–522.e4.. https://doi.org/10.1016/j.jaapos.2016.08.014.

2. Wang, B., Z. Saleem, R. R. Sigireddi, R. Naithani, S. Alvarez, A. P. Gregston and S. F. Freedman "Anterior segment structure after angle-based surgery in childhood glaucoma: descriptive findings using overhead-mounted optical coherence tomography." Journal of the American Association for Pediatric Ophthalmology and Strabismus (JAAPOS). In Press 2025.

3. Liu J, Puente MA, Edwards Mayhew RG, Smith CG, Mehner LC, Jung JL, McCourt EA. Corneal tomography under general anesthesia in the lateral decubitus position. J AAPOS. 2025 Apr 12:104205. doi: 10.1016/j.jaapos.2025.104205. Epub ahead of print. PMID: 40228578.

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2025-2026 Program Year

DATE	TOPIC	MODERATOR
September 19, 2025 **Venue:** **Marriott Copley Place**	AM – Cataract (with Hal. Freeman Lecture)	William Gensheimer, MD
	PM – Pediatrics	Bharti Gangwani, MD
	Ophthalmic Medical Personnel meeting	
December 5, 2025 **Venue:** **Hotel Commonwealth**	AM – Risk Management/Practice Management	Christopher Teng, MD, MBA
	PM – Cornea	Thomas Dohlman, MD
March 6, 2026 **Venue:** **Hotel Commonwealth**	AM – Retina (with Miller Lecture)	Archana Seethala, MD
	PM1 – Eye Care Delivery	Michael Boland, MD, PhD
	PM2 – Oncology	M. Reza Vagefi, MD
June 5, 2026 **Venue:** **Hotel Commonwealth**	AM – Uveitis (with Foster Lecture)	Paul Gaudio, MD
	PM1 – Glaucoma (with Simmons Lecture)	Erynn (Bo) Yang, MD
	PM2 – Update on Clinical Trials	Rachel Huckfeldt, MD, PhD

2026-2027 Program Year

October 2, 2026 AM – Practice management/Risk Mgmt. (with Hutchinson Lecture)
PM – Cornea
Ophthalmic Medical Personnel Meeting (all day)

Dec 4, 2026 AM – Glaucoma
PM1 – Videos of Latest Techniques
PM2 – Plastics (Cosmetic Surgery)

March 5, 2027 AM – Cataract (With Pender Lecture)
PM – Debates

May 21, 2027 AM – Retina (Taylor Smith Lecture)
PM1 – Neuro-op
PM2 – Rescue Therapies

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