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It Takes a Village, Part of the Focused Sight Initiative: Quality Improvement Interventions in Retinal Disease

Announcer:
Welcome to CE on ReachMD. This activity, titled “It Takes a Village” is provided by Evolve Medical Education.

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Dr. Eichenbaum:
I’m David Eichenbaum from Retina Vitreous Associates of Florida, director of research, and from the Morsani College of Medicine at the University of South Florida, and I’m very excited to present this case. This is a perfect case to talk about quality improvement and quality assurance. We entitled this case that *It Takes a Village* for this Evolve QI education program.

This is an 88-year-old female who complained of worsening vision in her left eye. She had long-standing vision loss in the right eye from severe anterior segment disease, which didn’t do well with treatment several years prior. She had had cataract surgery in both eyes, reasonably stable considering her advanced age. She has controlled conditions including CLL, hypertension, and has had some orthopedic work for age-related degenerative arthritis. Overall, quite functional, lives independently, is a nonsmoker, denies alcohol, does not endorse any sort of illicit substances. And she’s a retired fourth-grade teacher doing great at 88, all things considered, with vision loss in her right eye and visual impairment in her left eye.

Her functional acuity is probably poorer than her reading acuity, and you’ll see why when we get to the images. She’s 20/40 on the eye chart. The right eye has the impaired cornea with corneal edema. The intraocular lenses are stable in both eyes. Posterior segment, through the hazy anterior segment of the right eye, shows center-involving geographic atrophy; in the left eye, it shows non-center-involving geographic atrophy.

You’ll see she also has the stigmata of age-related macular degeneration. And this is a near-infrared on the left and a B-scan OCT through the fovea on the right of this patient at presentation. You can see, in addition to the multiple drusen, that she has a hyper transmission on the OCT consistent with what we see as the hyperreflective geographic atrophy lesions on the near-infrared. And even though her acuity is 20/40, with the geographic atrophy outside the center of the macula, it’s easy to see why she’s symptomatic in this better left eye.

We talk about treatment options, and we discuss the complement-modulating therapies. We talk about clinical trials. She does seasonally depart Florida, because it gets awfully hot where I practice, and she goes up to the Mid-South, which is a common location for our seasonal residents. And she elects to start with a monthly pegcetacoplan treatment. She starts the injections with me on the day of presentation. She does well and has good adherence to treatment.

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She sees me starting in June, when she developed this symptomatic vision loss. She stayed in Florida over the summer. This is the following summer. She does want to go back up north. Over the 12 months that I've been treating her, so she's received 10 pegcetacoplan treatments with excellent adherence. She feels that she has had some visual acuity decrease, and you'll see her images from this visit. We know that the complement-modulating drugs slow the growth of the geographic atrophy, but do not stop it. She's grateful that she's doing something to save her vision.

And she's heading up north to avoid summer in Florida for the 2025 season. And I typically coordinate care for these patients, and this is a very important piece of the case. I look at where she's going, and I select a retina specialist who I usually have had some kind of interaction with personally. Fortunately, our field is small, and I love our field because I can interact with folks literally all over the country—and the world—in our field, which is really wonderful. And they're friends that we've got with each other all around the country.

So we find a retina specialist, and I make a referral by sending a letter, giving the patient a copy of the letter, and making the patient an appointment at the retinal specialist practice that we specify, and we do this routinely for our seasonal patients. So she leaves, and I assume she goes to the retina specialist that I spent the time and made the referral for her to specifically see, because the treatment plan is transferred directly if there's good coordination of care. And my assumption is the patient will continue to receive treatment.

Here she is on that last day with me in the summer season in Florida. She does have, though, some expansion of the geographic atrophy lesion seen on the left side in the near-infrared picture compared to a year prior. She does still have drusen, she's got some encroachment towards the center of the macula, and hopefully, we're slowing this down with regular complement-modulating therapy.

So she comes back, very recently, with further vision loss in the left eye. She feels her vision has gotten worse. She saw a different out-of-state retina specialist than the one that we coordinated care for her with, and I don't know exactly how that happened. This other retina specialist was geographically a little bit closer to her, board-certified ophthalmologist, retina fellowship. For whatever reason, she did not tell us that she changed doctors to a different practice. She didn't bring her note to this doctor, and the doctor treated her for assumed neovascular macular degeneration with bevacizumab shots following the 10 pegcetacoplan shots.

So between June and November, she gets 4 bevacizumab shots for a diagnosis of controlled neovascular macular degeneration. She assumes her vision decreased more quickly, and she's confused and expresses this confusion to me and tells me she expressed this confusion to her out-of-state doctor, who she elected to see, why there was all this discussion of wet macular degeneration.

She's a very functional 88-year-old lady, and she knows that I spoke to her extensively about dry macular degeneration and what we were doing to treat that. When she returns to me, I try to explain to her that it sounds like there was some misunderstanding in her diagnosis. I try not to go into the weeds with this in this particular case because it is a confusing topic, and I understand why the doctor out of state thought that this patient had controlled wet macular degeneration.

I converted the patient back to pegcetacoplan treatment in November of 2025. Here you can see her macula in her more recent near-infrared on the left and OCT scan on the right. There is more extensive geographic atrophy. There's an enlargement of the hyper-reflective lesions on the near-infrared and an enlarging area of hyper transmission on the B-scan OCT on the right.

And I don't think this course was dramatically shifted by her receiving 4 bevacizumab treatments. I don't think there was a significant acceleration necessarily in her geographic atrophy. Yes, it is getting worse, but we know it gets worse even with good adherence to complement-modulating therapy. But she did receive 4 injections for a diagnosis that she doesn't carry, which didn't have any clinical utility and did have some incremental risk and cost and inconvenience and discomfort.

So in a search for improved quality, I wish that there was a way that I could have transmitted the information—or communicated the information and coordinated the care better with the retina specialist that she and her family ultimately chose for her to see. I did speak to the retina specialist after this on the telephone. I called the one that she elected to see, and he and I talked, and we're going to make sure she continues to get the appropriate treatment when she returns to the Mid-South this coming summer.

So in summary, the patient has done okay. This is obviously a quality problem when the patient's getting the wrong drug for the wrong diagnosis in the correct eye, at least. But I think that this type of thing could be mitigated with better patient understanding and easier-to-use patient portals. It could be mitigated with better communication between patients and their doctors.

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I wish that the patient had called us, or I wish she asked the doctor who she ultimately saw to call us. We take these calls all the time. I wish I had talked to her maybe more about her geography and how it was going to be inconvenient for her to go 20 or 25 minutes further out of her way to see the doctor that I coordinated care with her for.

So there were several places where the communication broke down, and that led to the inappropriate treatment for a diagnosis that she doesn't have. The solution to this is multifaceted, and I think it's taking these seasonal patients and hearing what their priorities are and meeting them where they are from my side as the Sun Belt doctor. And also telling the patients, if you change your plan, if you don't do what we are setting you up to do, just let us know, and we will make sure that the coordination is transferred to where you're going.

So ultimately, there is a fix. But this is a great example of an issue with communication and care quality that I think we could mitigate and do better with in the future.

Thank you for joining me and thank you for taking an interest in quality improvement and quality assurance and quality control for your care of retina subspecialty patients. This is something we don't talk about a lot. I think we don't talk about it enough. And I am grateful to be part of this educational initiative. I look forward to good feedback, and I look forward to all of us doing our best for our patients and for each other and trying to achieve the best visual outcomes that we can.

Announcer:
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