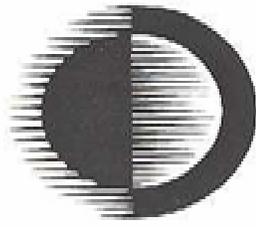


SPECIAL POINTS OF INTEREST:

- VisionAmerica's Commitment
- Opportunities for VisionAmerica to help your practice
- Continuing Education Opportunities
- VisionAmerica Faculty—See all our doctors, surgeries and locations
- 2012 Save the Date Calendar

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VisionAmerica

VOLUME 1, ISSUE 1

JANUARY, 2012

VisionAmerica's Commitment

VisionAmerica is committed to providing excellent medical and surgical eye care but also compliment the expertise of optometry and ophthalmology. Our mission has remained steadfast for over twenty years.

Successful co-management comes from a relationship built on trust and respect developed through shared learning, constant communication, and a commitment to provide outstanding patient care.

VisionAmerica Extends a Helping Hand

VisionAmerica is committed to the success of your practice. We recently started offering assistance to optometrists in several ways:

- Lectures to your staff or patients
- Brochure— assistance in designing a brochure for your office
- Health fairs—we will assist an employee at a healthfair in order to reduce the labor expense of more than one employee
- Community charity, civic or professional events to promote your practice

Please remember any unattached patients will be routed to the patients closest optometrist.

If you have any questions, or comments please forward to Lisa Williams at lwilliams@eyehealthpartners.com.

VisionAmerica's Mission Statement:

Since the development of Eye Health Partners in the 1980's, our mission has not changed. We are dedicated to provide the highest quality of eye care available while advocating the cooperative efforts of optometry and ophthalmology through clinical care, education and research.

Continuing Education



Watch for exciting news on how VisionAmerica can enlighten your Continuing Education experience.



We had an exciting year of continuing education within the VisionAmerica network.

The “2012 Save The Date” is published in this newsletter for your convenience. All Continuing Education lectures are subject to change. If you have a request for a class or speaker, please forward your request to Lisa Williams.

VisionAmerica is excited to offer online Continuing Education classes, which will count as distant learning.

Brown Bag Continuing Education lectures will continue in 2012. These lectures are held at lunch in the Huntsville Center each month.

VisionAmerica will also participate in zone meetings throughout the state.

VisionAmerica will continue

the technician training next year for the ALOA.

The Alabama Board of Optometry requires twenty hours of continuing education between October 1, 2011 and September 30, 2012. All hours obtained between October 1, 2011 and December 31, 2011 can be used for either 2011 or 2012 but not for both years. A maximum of three hours may be obtained through distant based lectures. A minimum of ten hours therapeutic lectures are required. One may also have three hours of practice management, and no more than five hours of observation. Call your center director to set up observation.

Last but not least, VisionAmerica Montgomery

will be hosting a golf tournament and an eight hour CE.

The golf tournament and VisionAmerica party will be Friday, August 10. The band is one of your very own optometrists.

The CE will be Saturday, August 11. VisionAmerica doctors will be the speakers.

The VisionAmerica party is for everyone, not just the golfers. You may bring a guest. This is an event you don't want to miss!

Southeast Diabetes Education and VisionAmerica

On August 27, 2011 the Montgomery office held an eight hour Continuing Education Class at Wynlake Golf and Country Club. There was no charge for the lectures, although a donation for the Montgomery area Southeast Diabetes Education was appreciated. Southeast Diabetes Education (SEDE) is a state wide organization to help awareness and education among children with Diabetes. They offer educational programs as well as “Camp Sugar Falls” day camp and Camp Seal Harris. We are grateful to all of you who contributed to this organization. The donation was one thousand dollars. If you would like more information on Southeast Diabetes education or one of the camps, please contact Lisa Williams.

LASIK... Seeing is believing

The field of refractive surgery has advanced tremendously since the 1980's when the first form of refractive surgery, called refractive keratectomy (RK), was performed in the United States. Today, our talented surgeons can select from a variety of refractive surgical treatments to help patients with vision problems.

Laser vision correction has been dominated by promotional television infomercials, radio spots and newspaper advertisements. Patients often have expectations about procedures that are significantly differed from reality.

However, a one-on-one consultation with one of our experienced doctors can help determine if they could improve vision through refractive surgery.

VisionAmerica is offering a 10% discount in Birmingham and Gadsden centers as a gift to you . Each optometrist will be able to share this savings with five patients. Please call Carley Self (205.943.4600) for appointments and information. The VisionAmerica website is there to help answer any questions that your patients may

have about refractive surgeries. Also, visit our facebook page *VisionAmerica Lasik*.



Be A VisionAmerica Friend

Become a friend to VisionAmerica on Facebook. We are listed as VisionAmerica Birmingham, Huntsville, Montgomery, and Mobile. Oxford center news can be viewed on VisionAmerica Gadsden. Please feel free to be friend all our facebook pages.

These pages are not open to the public. Only doctors, staff and business

associates will be allowed to join. Our facebook page will have updated news and events.

VisionAmerica LASIK is set up for the Birmingham center and is open to the public. We encourage you to have your patients visit this facebook page if interested in LASIK.

If you have a patient share why they would like LASIK, they will receive a

10% discount in Birmingham. Please feel free to contact our office for promotions throughout the year.

Be a
VisionAmerica Friend



See how one of your patients could receive 10% off LASIK.

*Additions to the
VisionAmerica Family*



Dr. Jeffrey Fuller is now seeing patients in Birmingham, Albertville, Cullman and Tuscaloosa



Dr. Ruben Grigorian is now seeing patients in Mobile and Eastern

Jeffrey Fuller, M.D.

Dr. Jeffrey Fuller is a board-certified ophthalmologist who is fellowship-trained in retina and vitreous.

Dr. Fuller earned his undergraduate degree from Brigham Young University in Provo, Utah. After completing two years of missionary services in Brazil, he obtained his medical degree from the University of Alabama School of Medicine in Birmingham, Alabama. Upon completion of an internship at Baptist Medical Center-Montclair, Dr. Fuller finished a residency in ophthalmology at The Medical College of Georgia, in Augusta. He then completed a fellowship in vitreoretinal medicine at the University of Iowa Hospital and Clinics in IowaCity, Iowa.

As a recipient of numerous awards and scientific grants, Dr. Fuller's research has led to numerous publications, scientific presentations and scientific posters. He has worked under mentors Peter Detloff, PhD., Robert Weiss, PhD., and Scott Woodward, PhD.

Dr. Fuller is a member of the American Society of Retinal Surgeons, the American Academy of Ophthalmology, the Association for Research in Vision and Ophthalmology, the American Society of Cataract and Refractive Surgery, the American Medical Association, the Southern Medical Association and other professional organizations.

Dr. Fuller is married to Laura Morris and they have six children. His hobbies include college football, political blogging, snow skiing and reading. He is fluent in Portuguese and conversant in Spanish.

Ruben Grigorian, M.D.

Dr. Ruben Grigorian is a board-certified ophthalmologist who is fellowship-trained in retina and vitreous.

After earning a Bachelor of Science degree from Yerevan State University in Armenia, Dr. Grigorian received his medical degree from the Yerevan State Medical Institute. Upon completing an ophthalmology residency at the Ophthalmology Center in Yerevan, he completed a second ophthalmology residency at the University of Medicine and Dentistry of New Jersey. Dr. Grigorian received his vitreoretinal fellowship training from the Louisiana State University in Baton Rouge.

Dr. Grigorian is a member of the American Academy of Ophthalmology. He is widely published in the area of retinal disease and treatment. .

Fluent in three languages, Dr. Grigorian speaks English, Russian and Armenian. He joins VisionAmerica from the Atlantic Retina Center in Salisbury, Maryland. He is married with one son, and his hobbies include sailing and tennis.



Paul Batson, O.D.

What's the big deal, it's just another cataract!

You're seeing Ms. Cataract back for her 6 month follow up and together you decide that it's time for surgery. You begin your standard cataract discussion that you've given at least 500 times. The question is: are you using the same cataract talk and thought process that you used 10 years ago, 20 years ago, or the one you used during the stone age (Dr. Marbourg)?

The reality is that technology and patient expectations have changed and therefore our patient management must change. From a patient's perspective, cataract surgery has become refractive surgery. In the past, the goal of cataract surgery was restoration of best spectacle corrected vision. More and more, the patients are judging their outcome based upon uncorrected visual acuity. My concern is that many of us are having a hard time changing habits. If we are going to provide the highest quality of patient care, then we need to face reality and be willing to change. I wanted to share just a few points to consider as you are seeing your cataract patient in hopes that this will assist with that change.

- What does your patient expect after surgery?
Are you asking them or have you seen them long enough that you know what they need? Make sure you start by asking what they expect from surgery.
- Is this a contact lens patient? If so, is the patient wearing monovision or multifocal contacts?
Help us improve outcomes by having these contact lens patients stay out of their contacts prior to their preoperative measurements. It's a 1:1 affect on the outcome – if our K's are off by .5D then the post operative refraction will be off by .5D, etc.
Make sure you address the post- operative expectations regarding near vision.
If the goal is to stay with monovision, make sure you communicate with your surgeon the planned refractive outcome for each eye.
If the patient is successful in multifocal contact lenses, review the option of a multifocal IOL with the patient.
- How much astigmatism does the patient have?
Is it corneal or refractive? When evaluating keratometry values of more than 1D of corneal cylinder, a toric IOL option should be discussed with the patient.

Bottom line: If the car you are driving or cell phone is more up to date than your cataract talk, then you need to reconsider. Patients deserve the highest quality of care that we can give. A significant portion of that care comes with simply educating patients about options they have available for the visual correction that comes with modern day cataract surgery. When talking with your patients, make sure that the cataract surgery plan matches their expectations. While we may not achieve a perfect outcome, it starts with having the game plan in place.

Paul Batson, O.D.

VisionAmerica Birmingham



Prophylaxis Against Intravitreal Injection Related Endophthalmitis

Numerous new and exciting papers were presented at the American Society for Retina Specialists and Retina Subspecialty day at the annual American Academy of ophthalmology meetings this year. One of the more interesting and practical topics was the use of prophylactic antibiotics with intravitreal injections. The following is a review of some of the considerations presented and my current approach.

Robert Mason, M.D. Endophthalmitis is a dreaded complication of in-office intravitreal injections and occurs at rates reported in the one case per several thousand ranges, in most studies. The news was recently rich with reports of 2 outbreaks of Avastin related endophthalmitis following intravitreal injections. The progression of a drug from its original components to what is eventually injected into a patient's eye is a multi-step process. Contamination, biotic or otherwise, is a potential at many of the steps regardless of the drug. An outbreak of deaths related to parenteral nutrition in some Birmingham hospitals, in the not too distant past, serves as a chilling reminder. This paper will focus on the phase between the final packaged product and its intravitreal application.

The primary concern for endophthalmitis is inoculation of ocular surface flora into the eye with the injection. Many studies have confirmed the patient's flora as a primary source of culture proven endophthalmitis post-surgery. Recently, some papers have suggested oral flora of the personnel involved in the injection process, however other studies have failed to support this hypothesis.

In either event, the only class 1A evidence for prophylaxis against endophthalmitis postoperatively or with intravitreal injections is the instillation of Povidone iodine (PI) immediately prior to incision of the skin. PI is readily available and inexpensive with the average cost of a 30ml bottle being \$12.00. There are no reported cases of resistance developing in response to PI, with a kill time reported in the range of 15-120 seconds and shown to be effective at concentrations from 0.005% to 10%. Povidone is the routinely chosen Iodine carrier and is hydrophilic. The iodine is delivered to the prokaryotic membrane where it is quickly destructive. PI does not require drying to kill, as is the case with alcohol.

Adverse reactions to PI are common. A 5% solution is usually chosen because it is the highest strength routinely tolerated. Despite this, ocular irritation and mild keratitis are the rule and not the exception for the first few hours after eye preparation. Research I have done has shown the pH to be more acidic than is desirable on the ocular surface. Unfortunately, alkalinization of the solution causes precipitation of the active product. I have had the greatest success in minimizing patient discomfort by having them keep their eye closed for 30 minutes after injection. I also give them a tear sample PRN on their way to the checkout desk. I am actively pursuing a less irritating formulation.

Other adverse reactions to PI generally come in the form of a contact dermatitis. This is fairly uncommon with short contact times. Anaphylaxis to Iodine does not exist. There are no reported cases of anaphylaxis related to topical preparation of an eye.

ASRS surveys of retina specialists continue to show a decrease in the proportion of surgeons using pre and post injection antibiotic prophylaxis. Topical antibiotics used before surgery do not confer additional benefit to PI at the time of surgery and do cause selective growth of resistance to the class of antibiotic used, usually a fourth generation fluoroquinolone. Unfortunately, many of the organisms are already resistant to another antibiotic thereby breeding multi-drug resistant bacteria. These poly-resistant flora are shown not only to sit upon the surface of the eye, but can be cultured out of the oropharynx of patients. As the primary source of bacteria involved in pneumonia, the oropharynx is a very undesirable location to have super-bacteria.

Identical principals can be offered in the case of post-injection prophylaxis. Additional concerns are the cost and potential side effects of the antibiotics. Because of this I stopped using pre or post injection antibiotics over two thousand injections ago and have yet to have a culture positive bacterial endophthalmitis following an intravitreal injection.

Many prescribe antibiotics after injection out of medico-legal concerns. The Ophthalmic Mutual Insurance Company (OMIC) insures about ¼ of all ophthalmologists in the United States. They have issued a statement declaring that they have received zero claims or lawsuits related to a lack of post-intravitreal injection antibiotics and suggest, "Decisions regarding use of antimicrobial and antiseptic prophylaxis should be based on best available science and not risk mitigation."

In summary, there is a continued trend towards the exclusive use of topical PI prior to injection as the sole means of antisepsis with intravitreal injections in the retina community. Local discomfort from PI continues to be a tolerable problem, but there is room for improvement. And, there is increasing concern over the potential negative ramifications of routine topical antibiotic use as prophylaxis against iatrogenic endophthalmitis.



David Judge, M.D.

Keratoconus – Future Tense

Keratoconus (KC) is a fairly common non-inflammatory corneal disease which causes thinning and protrusion of the cornea. The incidence is between 1:2000 and 1:5000, with a worldwide distribution and no gender or racial predilection. No specific etiology has been identified although there are several well-described characteristics.

Upregulation of degradative enzymes such as acid esterase, acid phosphatase and matrix metalloproteinases occur, leading to a significant decrease in total corneal protein. Certain proteinase inhibitors are downregulated. Keratocytes in KC have 4 times the Interleukin-1 (IL-1) binding sites compared to those of non-KC corneas. IL-1 causes apoptosis (a programmed cell death) of keratocytes.

There is a strong concordance of KC in monozygotic twins which suggests a genetic influence. However, the pattern of inheritance is unknown and the frequency of inheritance is estimated at only 6-7%. Much research must be done to identify the gene(s) responsible for KC.

The pathological findings of KC include degenerative changes in the basal epithelium, its basement membrane and Bowman's layer. Iron deposits in and between the basal epithelial cells are characteristic. The collagen lamellae are decreased in number but are of normal size. A fine granular material produced by the keratocytes is deposited in the stroma.

We are all familiar with the clinical findings of KC. Slit lamp exam shows characteristic vertical striae which disappear with pressure on the eye, the Fleischer iron ring at the base of the cone, and of course the conical protrusion itself. Corneal topography is invaluable in detecting KC as is corneal tomography which may show posterior corneal steepening as an early sign of the disease.

In the past treatment has consisted of glasses or contact lenses for early or mild KC and leans more toward surgery (Intacs or cornea transplant) for more advanced cases. It is estimated that 20% of patients with KC require cornea transplant. However, because it is not uncommon, it is the 2nd most common diagnosis leading to this procedure (Fuchs' dystrophy is #1). Although Penetrating Keratoplasty (PK) enjoys a high success rate, it is not without significant risks which are life-long, and usually begin at a fairly young age. Most corneal surgeons have seen a number of patients with ruptured PK incisions from trauma, transplant rejection or vascularized corneas, and infectious disease which can be related to sutures and/or prolonged steroid use. All of us have seen patients with high astigmatism after PK. These complications may leave the patient with a poor visual outcome.

What if we could arrest the progression of KC and avoid the risks of PK? I believe a huge paradigm shift in the management of KC is about to occur. At the root of it is corneal collagen crosslinking (CXL). In this relatively simple procedure the intra and interfibrillar covalent bonds of the corneal collagen are increased by photosensitized oxidation. Riboflavin is the photosensitizer. This leads to a biomechanical strengthening of the cornea which stops the progression of KC.

This concept came from a German ophthalmologist, Theo Seiler in the mid 1990's. The procedure has been performed in Europe in human KC since 2005. Data from long-term studies (4-5 years) is showing stabilization of the corneal curvature in eyes that were progressing with KC.

The original protocol involved removing the corneal epithelium to allow better absorption of riboflavin. More recent studies have attempted to achieve the same results without removing the epithelium. This would allow for less discomfort and less risk of infection, delayed epi healing and corneal haze/scar, which can occur with the original technique. Some ophthalmologists are studying the combination of CXL with topographically linked excimer laser treatments to induce a more dramatic shape change in the cornea. These results are short-term followup only.

The future of KC management will involve early detection, monitoring for progression, and a treatment that will effectively halt the disease. This will allow more success in vision preservation without nearly as many patients requiring cornea transplants. Cornea transplants will still be needed in advanced cases, and this procedure itself will continue to evolve and improve. I am cautiously optimistic that CXL will gain FDA approval in my lifetime, (if not my career), and the U.S.A. will join the rest of the civilized world in being able to offer it.

The future is bright for those suffering from KC. It is up to us to strive for better treatment strategies and to identify those who will benefit from them.

David A. Judge, M.D.
VisionAmerica Gadsden



Peter Zloty, M.D.

A Brave New World: Corneal Collagen Crosslinking

“If my 12 year old son had keratoconus, I would crosslink him”. This was an assertion by a physician (not a speaker, thank God) in a session on collagen crosslinking held in Sydney at the 2011 APAO. He seemed bright enough, but his evangelistic fervor over the procedure seemed “over caffeinated” to me.

At the time of this writing, devices used for Collagen Crosslinking do not yet have FDA approval. But across the globe the number of procedures is increasing steadily. For the unconverted, the procedure is performed by removing the corneal epithelium, applying a solution of Riboflavin, and exposing the cornea to ultraviolet light. The procedure usually takes between 30 to 45 minutes. The procedure goes by the moniker Corneal Crosslinking, or CCLx, even when the goal of treatment has nothing to do with collagen fibril strengthening, such as in “collagen crosslinking for microbial keratitis”. Granted there have been positive results. Corneas have become stiffer, and, in some studies, progression of keratoconus may be arrested. Unfortunately the data on collagen crosslinking has been adulterated by the very enthusiasm mentioned above. The truth is, it is hard to find pure crosslinking data. Studies abound with “crosslinking plus”, the plus being anything from Kerratings and Intacs, to RGP lenses, devices themselves that influence the data.

Additionally, the results are underwhelming, which is ironic in a specialty which agonizes over such things as intraocular lens selection to compensate for age induced corneal aberration. By comparison the benefits shown with CCLx seem even more trivial. A 49 D cornea which improves to become a 48.25 D cornea after an invasive treatment seems a modest benefit, at best. Improvements in lines of vision are also not of real life benefit in most studies. So what if a 20/200 eye which becomes a 20/100 eye? The positive trend does not counteract the fact that 20/100 vision is crappy vision.

The goal of treatment is also unconventional. Most of our other interventions are done to create a more youthful eye, replacing the cloudy lens with a clear one, raising a droopy lid, lowering intraocular pressure, etc. Instead, the goal of crosslinking is to advance the cornea to a highly cross-linked state, that of an aged cornea. Furthermore we already know this since keratoconus progression slows down as the patient nears the late forties and fifties. We also know that unhealthy conditions like uncontrolled Diabetes mellitus and cigarette smoking increases collagen crosslinking. One wonders if having the patient smoke a cigarette or two during the thirty minutes of ultraviolet exposure would enhance the treatment. I was wondering about this as I squinted through the bright sunlight of Sydney Harbor while wearing my UV blocking sunglasses.

The question remains, is having a 50 year old cornea at age 12, or even 23 really such a good thing? The answer may have been offered by a 23 year old Saudi Arabian exchange student who was attending a local university. He brought me his medical records, a brief review revealing he had one corneal crosslinking event in his native country prior to his arrival in Mobile, Alabama. His Pentacam measurements preoperatively showed 1.5 D of more corneal asphericity than my exam. His best spectacle corrected vision having gone from 20/150 to 20/80 in his worse eye. His uncross linked eye was 20/70. He had failed a local driving examination. When I explained I could not, by law, finish a course of cross linking treatment, he was incredulous: “But this is America!” He supposed we had the best health care system in the world. But as a consolation I sent him to my optometrist who fitted him with a composite soft/RGP lens. He was 20/20 a short time later. His (very appropriate) question was “why don’t they have this technology available in my country”? Maybe we still do have a good health care system.

As he left my office, about to retake his driving examination, I reflected on the fact that I really liked that I was not a party to accelerating the age of his cornea by nearly two decades. Speaking of age, I am also old enough to remember another time when evangelistic fervor overtook our profession. I endured cheerleaders being paraded out in front of surgeons who shouted “RK is OK”. Now I will not go so far as to claim that CCLx may be the radial keratotomy of this generation, but the fact remains that no one really knows. Kudos to the FDA on careful deliberation on the devices used for CCLx. One wonders at the public health benefit if micrometer diamond scalpels had been as carefully considered.

Respectfully Submitted,
Peter Zloty M.D.
Corneal and External Disease and Refractive Surgeon

VisionAmerica of Mobile

Main Offices, Medical Staff, Specialties

Birmingham	Cullman	Gadsden	Huntsville	Huntsville	Mobile
State Farm Parkway Birmingham, AL 35209 800.467.3937 205.943.4600 205.943.4660 fax	1979 AL Hwy 157 Cullman, AL 35058 256.734.9613 256.734.5005 fax	2015 Rainbow Drive Gadsden, AL 35901 256.547.2025 256.547.2019 fax	1150 Eagletr Huntsville, 877.365 256.533 256.533	Lee Lane SE AL 35801 .3092 .8801 .8803	3290 Dauphin Street Suite 401 Mobile, AL 36606 251.471.3309 251.471.5046 fax
Montgomery	Athens	Jasper	Oxford/A	Montgomery	Albertville
Cotton Gin Road Montgomery, AL 36117 334.323.3610 866.630.9617 334.323.3629 fax	1207 East Forrest Street Suite H Athens, AL 35611 256.216.5860 256.216.5862 fax	205 Oak Hill Road, Suite A Jasper, AL 35504 205.295.2268 205.295.2270 fax	715 Snow Oxford, A 256.241 256.241.6	W Street L 36203 .6160 171 fax	312 Sand Mountain Dr, E Albertville, AL 35950 256.279.0817 256.279.0855 fax

Specialties

Anterior Segment/General Ophthalmology

Topical/Clear Cornea Cataract Surgery
YAG Capsulotomy
Argon Laser Trabeculoplasty
Selective Laser Trabeculoplasty
Laser Peripheral Iridotomy
Pterygium Surgery
Corneal Transplant/DSEK
Phacoviscocanalostomy
Trabeculectomy/Glaucoma Mini Shunt

Vitreoretina

Focal laser
Pan Retinal Photocoagulation
Laser Treatment of retinal tears/holes
Vitreotomy
Retinal Detachment repair
Macular Surgery

Anti-VEGF Therapies

Oculoplastics

Blepharoplasty
Ptosis repair
Forehead lift
Botox
Entropion/Ectropion
Tumor biopsy/excision
Orbital Surgery: *Decompression, Orbital Fractures, Tumors*

Strabismus

Multiple muscle procedures
Repair of stretched muscle scars

Neuro-Ophthalmology

Refractive

IntraLase Blade-Free LASIK with CustomVue Treatments
Surface Treatments: *LASEK, PRK, Epi-LASIK*
Conductive Keratoplasty
INTACS Intrastromal Corneal Rings
Anterior Chamber ICL
Visian ICL (Phakic IOL)
Clear Lens Extraction
Traditional Monofocal IOL
Crystalens Accommodating IOL
AcrySof ReStor Apodized IOL
AcrySof Toric IOL

Birmingham	Cullman	Gadsden/Oxford	Huntsville	Mobile	Montgomery
Paul Batson, OD Center Director	James Marbourg, OD Regional VP / Exec. VP	Stacy Clark, OD Center Director	Tracy Swartz, OD, MS, FAAO Center Director	Tara Smith, OD Center Director	Brian Mahalak, OD Center Director
Matthew Albright, MD. Cornea , Refractive Surgery & Cataract Surgery	Jill Helton, OD Center Director	David Judge, MD Cornea , Refractive Surgery & Cataract Surgery	Irene Ludwig, MD Pediatric & Strabismus	Peter Zloty, MD Cornea , Refractive Surgery & Cataract Surgery	Gregory Hoffpauir, MD Anterior Segment
Jeffrey Fuller, MD Vitreoretina	Robert Mason, MD Vitreoretina	Robert Mason, MD Vitreoretina	David Judge, MD Cornea , Refractive Surgery & Cataract Surgery	Ruben Grigorian, MD Vitreoretina	Darrell Wolfley, MD Oculoplastics
Irene Ludwig, MD Pediatric & Strabismus	Donald McCurdy, MD Anterior Segment	Darrell Wolfley, MD Oculoplastics	Brian Mulrooney, MD Anterior Segment		
Robert Mason, MD Vitreoretina	Jeffrey Fuller, MD Vitreoretina		Darrell Wolfley, MD Oculoplastics		
Donald McCurdy, MD Anterior Segment					
Robert Morris, MD Vitreoretina					
Matthew Sapp, MD. Vitreoretina					
Darrell Wolfley, MD Oculoplastics					



Continuing Education

**SAVE
The
DATE 2012**

- > Clinic Lectures
- > Brown Bag Lectures
- > Online Lectures
- > Technician Lectures
- > Golf Tournament & CE
- > Zone Lectures

- Please RSVP for details and changes.
- Visit our Facebook page

RSVP: Lisa Williams
 Director of Marketing
 Phone/Text 334-796-7466
 Email:

lwilliams@eyehealthpartners.com

Clinic Lectures

January 19	461 Cotton Gin Road, Montgomery, AL
February 16	2015 Rainbow Drive, Gadsden, AL
March 6	715 Snow Street, Oxford, AL
March 22	3290 Dauphin St., Ste 401, Mobile, AL
April 5	250 State Farm Parkway, Birmingham, AL
April 19	461 Cotton Gin Road, Montgomery, AL
June 12	2015 Rainbow Drive, Gadsden, AL
July 17	3290 Dauphin St., Ste 401, Mobile, AL
October 9	250 State Farm Parkway, Birmingham, AL
October 23	715 Snow Street, Oxford, AL
November 8	3290 Dauphin St., Ste 401, Mobile, AL
November 15	461 Cotton Gin Road, Montgomery
December 8	250 State Farm Parkway, Birmingham, AL

Brown Bag Lectures

Brown Bag Lectures are 2 CE hours and are held at 1150 Eagletree Lane, SW, Huntsville, AL

January 27	Lids and Lashes Update
February 24	Night Vision Problems
March 30	Healing the Cornea
April 27	HIV Update
May 25	Ordering Tests: What, How and When
June 29	Pupil Review
July 27	Vitamins in the Literature
August 31	Grand Rounds
September 28	TBA
October 19	TBA

Online CE

You are allowed three distant learning hours per year. Visit gotovisionamerica.com to view the online CE.

ALOA and VisionAmerica Technician Lectures

This program is tentatively set for one Saturday a month in March, April and May.

Golf Tournament and Eight Hour CE

August 10	Wynlakes Golf and Country Club Starting time 12:00 pm - Fee \$100. per golfer VisionAmerica Social Starting time 7:00 pm - 11:00 pm Food, Fun, Live Band and Cash Bar
August 11	Eight VisionAmerica doctors to speak on a variety of topics.

Zone Meetings

March 13	Tuscaloosa Zone
May 17	Mobile Zone
July 12	Montgomery Zone
September 13	Birmingham Zone

Other Dates To Remember

Feb 29— March 4	SECO
June 27- July 1	AOA—Chicago
July 27—28	ALOA Summer Conference—Grand Hotel, Marriott Resort Point Clear, AL
August 24 –26	UAB Alumni Weekend
October 24—27	AAO Phoenix
November 2—4	ALOA Fall Conference—Winfrey Hotel