

# Case Files: The Glaucoma Chronicles

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## Financial Disclosure – Justin Schweitzer, OD, FAAO

- Aerie - C/L
- Alcon - C/L
- Allergan - C/L
- Bausch + Lomb - C/L
- Ocular Therapeutix - C
- EyePoint - C
- Sight Sciences - C/L
- Dompe - C
- Zeiss - C/L
- Visus - C
- Science Based Health - C
- Kala - C
- RVL - C
- Sun - C/L
- Equinox - I
- Reichert - C
- 183 - C/L
- Glaukos - C/L
- Horizon - C
- Quidel - C
- MediPrint - C
- LKC - C/L
- Avellino - C
- Novartis - C
- Iveric bio - C
- Occuphire - C

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## FINANCIAL DISCLOSURES-JESSICA STEEN OD, FAAO

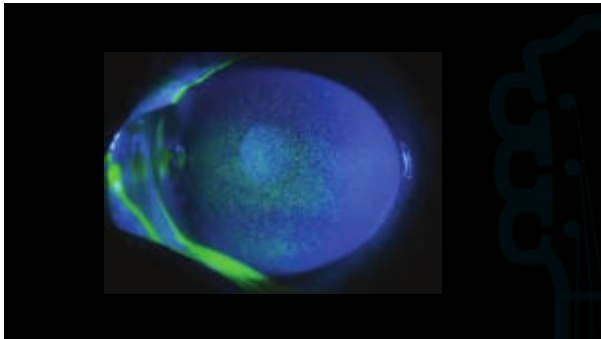
- Speaker-Carl Zeiss Meditec, Bausch and Lomb, Oyster Point Pharma, Thea Pharma, Alcon, Allergan, Astellas, Dompe
- Advisory Board-Bausch and Lomb, Carl Zeiss Meditec, Santen, Peripherex, Ocuphire, Ocuterra, Oyster Point Pharma, Allergan, Astellas, Radius XR
- Shareholder-Clearside Biomedical (<0.01% ownership)
- All relevant relationships have been mitigated

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## Case 1

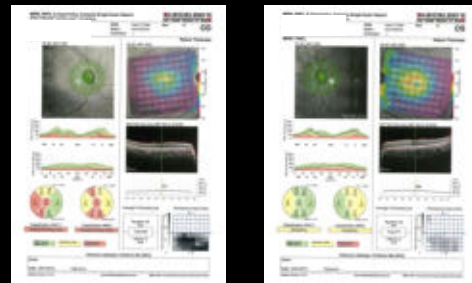
- **71-year-old African-American male – irritated eyes.**
- **Medical History:** HTN
- **Family History:** HTN, DM
- **BCVA:** 20/20 +1 OU
- **TMAX:** 29 mm Hg OD; 28 mm Hg OS
- **Ocular Meds:** Latanoprost qd OU, fixed combo agent bid OU
- **IOP:** 20 mm Hg OD; 19 mm Hg OS
- **C/D:** 0.75/0.75 OD 0.65/0.65 OS
- **Pachymetry:** 510 OD; 514 OS
- **Corneal hysteresis:** 8 OD 8.9 OS
- **Gonioscopy:** Open to CB OU w/ trace pigment in TM
- **SLE:** PCIOL OU and See image
- **VF's** – See next slide
- **OCT's** – See next slide

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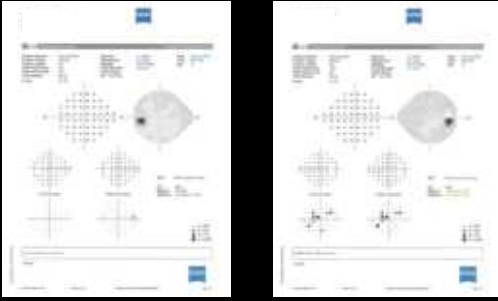
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## OCT's



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Visual Field's



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What Would You Do?

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Case Conclusion

- Performed bimatoprost SR + SLT OU – gave patient “drop holiday”
- IOP 17 OD; 16 OS @ 6 weeks – eyes feel so much better
- Monitoring the patient every 4 months initially
- Recent visit – stable VFT, OCT, and IOP (schedule q 6 mos)

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Impact of Multiple Glaucoma Medications on Dry Eye Disease

Number of Drops	Incidence of DED among 61 glaucoma patients <sup>1</sup>	Incidence of DED among 19,665 glaucoma patients <sup>2</sup>
1	11%	51%
2	39%	55%
3+	40%	60%

DED: Dry eye disease index  
 1. Fakhour RD et al. Cornea. 2010;27(4):418-421. 2. Ehr C et al. Graefes Arch Clin Exp Ophthalmol. 2008;46(1):150-160. 3. Leung EW et al. J Glaucoma. 2008;17:350-355.  
 Slide Courtesy of Paul Singh MD

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Effects on Meibomian Glands

Effect on lids/meibomian glands  
 Study on glaucoma patients 18mo stable treatment with different drop regimens.  
 Reduced number of meibomian glands  
 Reduced numbers of acinae and increased dysfunction in patients  
 Patients on multiple medications with preservatives = increased dysfunction and reduced number of acinae

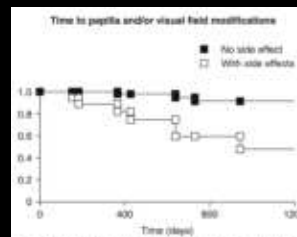
Study	Medication	MP	SP	Control (Healthy)	MP/SP (Mean)	MP/SP (SD)
Control	MP	10000	10000	10000	10000	10000
	SP	10000	10000	10000	10000	10000
MP Reg	MP	10000	10000	10000	10000	10000
	SP	10000	10000	10000	10000	10000
MP/SP Reg	MP	10000	10000	10000	10000	10000
	SP	10000	10000	10000	10000	10000



Agnifili L, et al. Br J Ophthalmol 2013.

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Treatment Challenges



• Dore, Philippe et al Medical outcomes of glaucoma therapy from a nationwide representative survey

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## Preservative-Free Solutions

### PF-Latanoprost

	Phase 3 (US) Trial (n=325)		Phase 3 (Europe) Trial (n=353)	
	PF-Latanoprost	Xalatan	PF-Latanoprost	Xalatan
Mean baseline IOP ± SD(mmHg)	18.8 ± 2.9	19.2 ± 3.1	24.1 ± 1.8	24.0 ± 1.7
Mean IOP reduction from baseline (mmHg) (range)	2.7 (2.2-3.0)	3.4 (2.9-3.8)	8.6 (8.3-8.8)	8.9 (8.8-9.0)

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## BAK-Free Latanoprost

## Preservative-Free

- Following instillation, micelles mix with the tear film
- As the micelles migrate toward the ocular surface, they break apart, releasing latanoprost



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LIGHT trial: 6-year results of primary selective laser trabeculoplasty versus eye drops for the treatment of glaucoma and ocular hypertension.

Gus Gazzard, Evgenia Konstantakopoulou, David Garway-Heath, Marlam Adeleke, Victoria Vickerstaff, Gareth Ambler, Rachael Hunter, Casey Bunce, Neil Matthews, Keith Barton, on behalf of the LIGHT Trial Study Group

Primary Outcome - Quality of Life at 6 years  
Secondary Outcome - clinical effectiveness and safety

#### Conclusions:

No significant difference in QOL  
26.8% VS 19.6% progressed drops vs SLT  
Trab required in 32 eyes in drops arm compared to 13 eyes in the SLT arm  
69.8% of SLT Drop Free @ 6 Years

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## Low-Energy SLT Repeated Annually: Rationale for the COAST Trial

Tony Realini, MD, MPH, Gus Gazzard, MD, Mark Latina, MD, Michael Kass, MD

Newly diagnosed POAG treated with:

1. ALT 360 x 1
2. Standard SLT 360 as needed
3. Low-energy SLT 360 repeated annually

#### 10-year Results

Medication Free Rates

1. ALT - 22.6%
2. Standard SLT -25.0%
3. Low-energy SLT - 58.3%

#### 10-year Results

Median Times to Treatment

1. ALT - 2.8 years
2. Standard SLT -3.2 years
3. Low-energy SLT - 6.2 years

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## Glaucoma Drug Delivery

Bimatoprost SR <sup>(Allergan)</sup>  
(10-microgram bimatoprost sustained-release implant)



- Biodegradable bimatoprost sustained-release implant
- FDA-approved and indicated to reduce IOP in patients with open angle glaucoma or OHT
- Single intracameral administration
- Phase I/II/III Studies

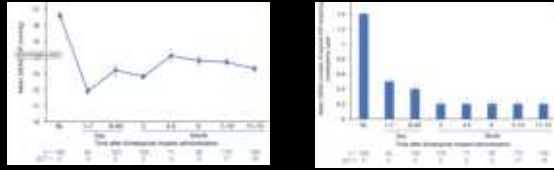


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Real-World Study of the Effectiveness and Safety of Intracameral Bimatoprost Implant



Teymouriyan S, Craven ER, Nguyen L, Werts E. Real-World Study of the Effectiveness and Safety of Intracameral Bimatoprost Implant in a Clinical Setting in the United States. Clin Ophthalmol. 2024;Jan 19;18(1):197-199. doi: 10.2147/OPTH.S445005. PMID: 38263954; PMCID: PMC10804876.

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Travoprost intraocular implant (Glaukos)

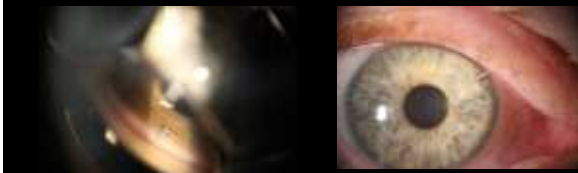
Resides in AC angle, anchored behind TM



- Length: 1.8 mm
- Diameter: 0.5 mm
- Titanium
- Non-ferrous

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Travoprost intraocular implant (Glaukos)



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**36 Month Update**  
 1. 70% and 68% of subjects in fast and slow-release were well-controlled on fewer or same medications as baseline.  
 2. Average IOP reductions were 8.3 mmHg and 8.5mmHg in the fast and slow-release arms.

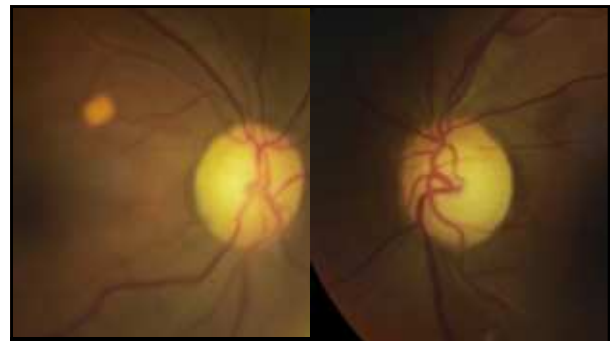
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RETINAL PATHOLOGY OR GLAUCOMA?

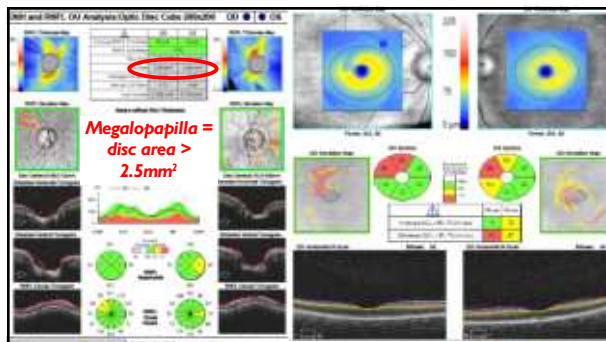
- 64 year old Black male referred for evaluation of suspicion of glaucoma due to screening field abnormality
- CCT 540µm ish OD and OS



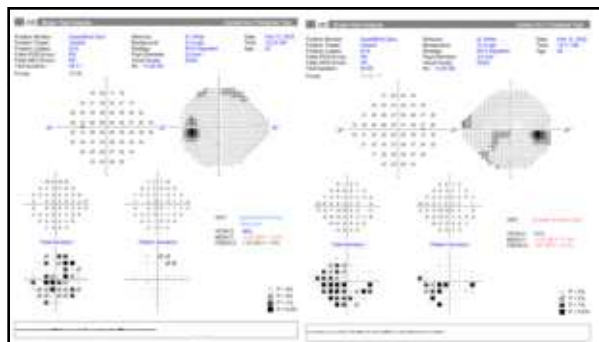
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**Is this glaucoma?**

**Megalopapillae (disc diameter >2.50mm<sup>2</sup>)**  
**Average CCT**  
**IOP statistically within a normative range**

**Retinal nerve fiber layer defect—in the absence of notching of the neuroretinal rim**

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**What else can cause RNFL defect?...and therefore visual field defect?**

**Retinal ischemia**  
 Diabetes mellitus,  
 hypertension, systemic  
 lupus erythematosus

**Nonarteritic ischemic optic neuropathy**

**Optic disc drusen**  
 ...

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**Glaucoma is a progressive, chronic optic neuropathy**

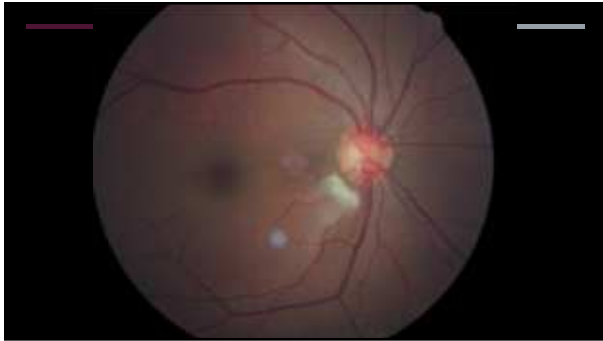
**Is there change over time?**

**Take the time that you need to establish a diagnosis**

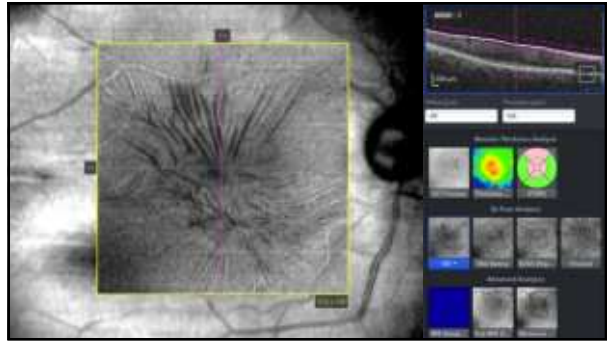
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**Case #2**

**65-year-old, Caucasian female referred for a second opinion for possible glaucoma. She states she has never had high eye pressures and doesn't understand how she could have glaucoma.**

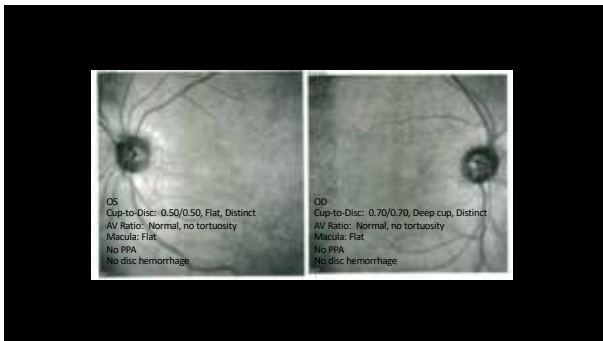
<p><b>Ocular History</b></p> <ul style="list-style-type: none"> <li>• <b>POHX:</b> Cataract extraction OU 2014, YAG capsulotomy OU 2014</li> <li>• <b>FHX:</b> Mother – glaucoma, age-related macular degeneration</li> <li>• <b>Previous Treatment Regimen:</b> None</li> <li>• <b>Current Treatment Regimen:</b> None</li> <li>• <b>IOP max</b> <ul style="list-style-type: none"> <li>• OD: 17 mm Hg</li> <li>• OS: 17 mm Hg</li> </ul> </li> </ul>	<p><b>Medical History</b></p> <ul style="list-style-type: none"> <li>• <b>PMHX:</b> Hyperlipidemia</li> <li>• <b>All Medications:</b> Fluoxetine, Atorvastatin</li> <li>• <b>Allergies:</b> Penicillin</li> <li>• <b>Blood Pressure:</b> 118/75</li> </ul>
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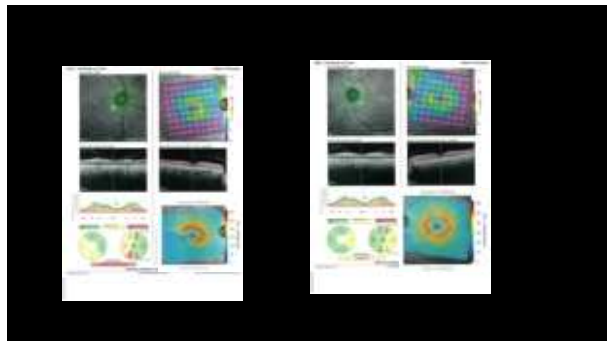
**Ocular Exam**

- **Uncorrected visual acuity (UCVA):** 20/20 OD, 20/20 OS
- **External exam:** Normal appearance, symmetrical
- **Pupil exam:** Equal, round, reactive to light and (-) APD
- **Slit-lamp exam**
  - **Lids/Lashes:** Clear, no debris, no signs of MGD OU
  - **Conjunctiva:** Clear, no injection OU
  - **Cornea:** Clear, no corneal staining OU, no pigment present OU
  - **Anterior Chamber:** Clear, no cells, no flare OU
  - **Iris:** Clear, no exfoliative material present, no transillumination defects OU
  - **Lens:** Well centered posterior chamber intraocular lens, open posterior capsule OU
- **Goldmann Applanation Tonometry:** 16 mm Hg OD, 17 mm Hg OS
- **Central corneal thickness (CCT):** 499 OD, 504 OS
- **Gonioscopy:** Open to CB in all quadrants, no pigment in the TM, and normal iris approach
- **Corneal Hysteresis:** 9.4 mm Hg OD, 9.3 mm Hg OS

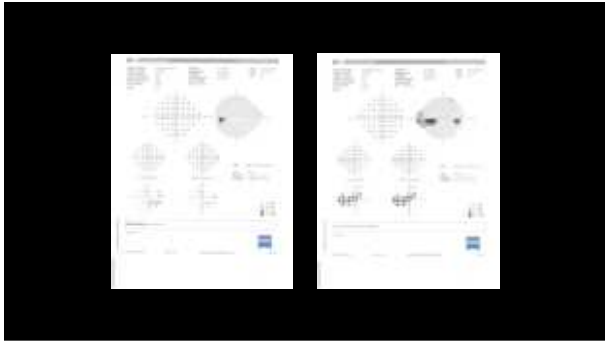
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## Diagnosis

Moderate Normal Tension Glaucoma OD  
 Pre-perimetric Normal Tension Glaucoma OS

**Other diagnoses:** SPO Cataract Extraction OU, SPO YAG Capsulotomy OU

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# What Would You Do?

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## Initial Follow-up and Plan

**Follow-up at 1 month**

latanoprostene bunod 0.024% was well tolerated, easy to instill, and patient states compliance with medication.

Follow-up ocular exam: Vision and SLE stable from last examination 1 month ago.

Tonometry:  
 OD: 12 mmHg  
 OS: 12 mmHg

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**Normal tension glaucoma (NTG)** is an optic neuropathy associated with glaucomatous optic nerve head damage, progressive retinal nerve fiber layer thinning, characteristic visual field defects, open anterior chamber angles on gonioscopy and maximum intraocular pressure (IOP) below 21 mmHg.

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## Normal Tension Glaucoma –Landmark Studies

- Only 50% of treated eyes achieve a 30% IOP lowering
- 34% of treated NTG patients show progression
- 9.9% of NTG patients go blind in 1 eye
- 1.5% of NTG patients go blind in both eyes

Lowering IOP 20-30% slows progression significantly  
 A 20-30% reduction of IOP confers a 93-96% chance of stability  
 Achieving an IOP of 10-11mmHG confers a 90% chance of stability  
 Achieving a 20% reduction results in 1.4-fold reduction in Progression  
 Achieving a 40% reduction results in a 5.7-fold reduction in Progression

1. The advanced glaucoma intervention study (AGIS). *Am J Ophthalmol*. 2000;130:429-440.  
 2. Scharer JP, et al. Iopidine-related conversion to the retrolental fibrous membrane in the advanced glaucoma intervention study: comparing diurnal treatment randomized to medications or surgery. *Ophthalmology*. 2001;108:1941-1951.  
 3. The effectiveness of intraocular pressure reduction in the treatment of normal-tension glaucoma. Collaborative Normal-Tension Glaucoma Study Group. *Am J Ophthalmol*. 1998;124:499-505.  
 4. Bhatta R, et al. Early Warning Glaucoma Trial Group. Reduction of retinopathy progression and glaucoma progression. Results from the early warning glaucoma trial. *Arch Ophthalmol*. 2002;120:1268-1274.

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## RISK DISEASE FACTOR

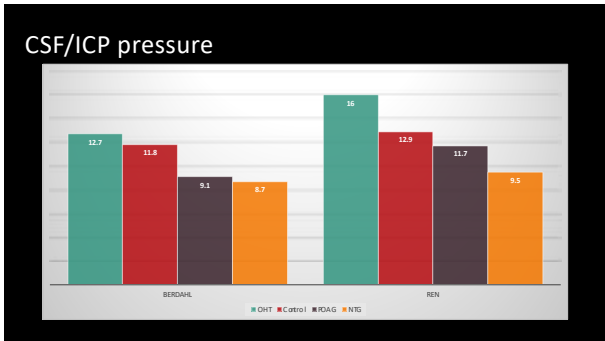
- Increased IOP
- Nocturnal and Diurnal IOP Rise
- Female
- Myopia
- Age
- Hypotension
- Low ocular perfusion pressure
- Not Being Overweight
- Migraines/Raynaud's Phenomenon
- Sleep Apnea
- Thin Cornea or Low Corneal Hysteresis
- Decreased CSF Pressure

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## Degree of Nocturnal BP "Dip" in NTG patients & Glaucoma Progression

Keon, J., Lee, J., Choi, J., Jeong, D., & Kook, M. S. (2017). Association between nocturnal blood pressure dip and optic disc hemorrhage in patients with normal tension glaucoma. *American journal of ophthalmology*, 176, 87-101.

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## What Works When Our Patients Are Most Vulnerable To Glaucoma?

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## FYSX O-PAP (Ocular Pressure Adjusting Pump)

- Only nonsurgical, non-pharma way to lower IOP
- Lowers IOP in every eye, every time
- Lowers IOP safely
- Can be used in combination with existing therapies
- Titrates IOP to target pressure level
- Lowers IOP during the vulnerable period at Night
- Ability to monitor usage, encourage compliance, and obtain data

Lightweight, Comfortable Goggles

Quiet, Programmable Pump

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## THE SOLUTION IS BASED ON PHYSICS

- The atmosphere pressurizes the entire body
- By lowering the pressure only over the eye, it lowers the IOP relative to the rest of the body
- It's just physics, and physics works every time
- IOP can be dialed into the specific target

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## 2 Multi-Center Randomized Controlled Trials

### Apollo – Open-Angle Glaucoma

- N = 128 eyes of 64 Subjects
- Contralateral Eye Served as Control
- IOP Inclusion - 13-32 mmHg
- **POAG, NTG, OHT, and Glaucoma Suspects**
- 89.7% had IOP Reduction of >20%
- 100% of eyes had IOP Reduction
- **IOP decreased from 19.4 to 12.9 mmHG (34%)**
- IOP Decreased in addition to existing therapy
- IOP Decrease regardless of Baseline IOP
- No SAEs
- ~20% of eyes had temporary lid edema

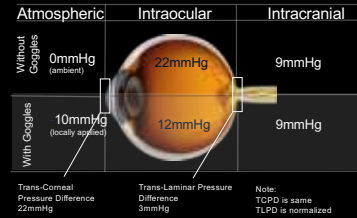
### Artemis – Normal Tension Glaucoma

- N = 182 eyes of 91 Subjects
- Contralateral Eye Served as Control
- IOP Inclusion - ≤ 21 mmHg
- **NTG Only – IOP Measure Overnight in Sleep Lab**
- 98.2% had IOP Reduction of >20% at night
- 100% of eyes had IOP Reduction
- **IOP decreased from 20.2 to 12.2 mmHG (39%)**
- IOP Decreased in addition to existing therapy
- IOP Decrease regardless of Baseline IOP
- No SAEs
- ~17% of eyes had temporary lid edema

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## Treatment in glaucoma



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### 63 YEAR OLD WHITE MALE

- History of "narrow angles" and bilateral LPI
  - 25 years ago (1999)-at the age of 38
- Latanoprost QHS OU (teal cap)
  - Reported peak untreated IOP high 20s
- Systemic hypertension and anxiety
  - Lisinopril
  - Clonazepam
    - No events of significant blurred vision, haloes around lights, significant nausea, or headache

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### 63 YEAR OLD WHITE MALE

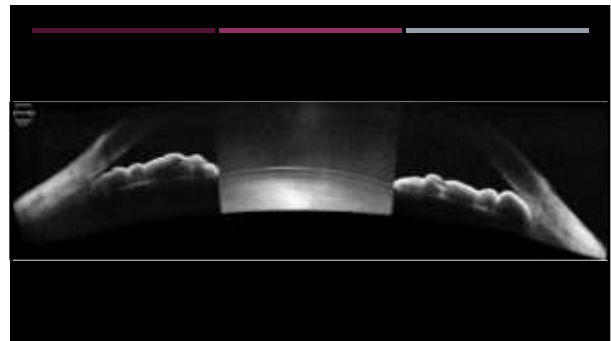
- BCVA 20/20 OD and OS
  - +2.00D OD and OS
- Patent LPI 1:00 OD and OS
  - What does LPI do?
    - Reverse or prevent pupil block
- Moderately deep central anterior chamber
  - Anterior trabecular meshwork 360 degrees OD; 270 degrees OS with no structures temporal
    - Convex iris approach; no PAS, AR, NVA
    - 1+ pigment with compression

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## OCT Evaluation of the Anterior Chamber

- **No inadvertent compression**
- **May be performed in complete darkness**
- **Most valuable to determine if the angle is open or closed**

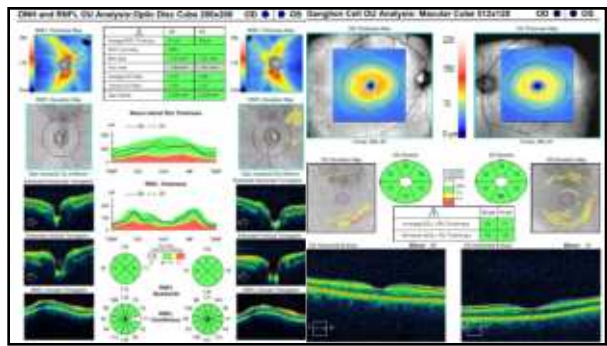
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**Does this patient need to be on treatment?**

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**TERMINOLOGY**

- 1) Primary angle closure suspect
- 2) Primary angle closure
- 3) Primary angle closure glaucoma
- 4) Acute angle closure crisis

**Either open or closed**  
*There is no such thing as "narrow angle glaucoma"*

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**PRIMARY ANGLE CLOSURE SUSPECT**

- Discontinue latanoprost: 18mmHg OD/17mmHg OS at follow up
- Advocate for early cataract surgery
- **Does this patient meet EAGLE inclusion criteria?**

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**Effectiveness of early lens extraction for the treatment of primary angle-closure glaucoma (EAGLE): a randomised controlled trial**

Augustine Alexander, Jennifer Burn, Craig Bennett, David Cooper, Paul Francis, David Freedman, Graham Goodfellow, Mohit Goyal, John Haines, John Haines (for the EAGLE study group)

- Removal of clear lenses in eyes with PACG with IOP > 21 mmHg or eyes with PAC (without glaucoma) and IOP >30mmHg vs. LPI (and medications); greater than 50 years of age
- Clear lens extraction patients had greater IOP control and improved quality of life
- Patients who underwent lens extraction had fewer IOP lowering medications
  - Only 1 needed trabeculectomy after phaco whereas 24 patients in the LPI group needed trabeculectomy
- Cost-effective at 3 years; savings by 10 years
  - Fewer procedures, fewer office visits
- Clear lens extraction can be considered

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Local Coverage Determination (LCD)

## Cataract Surgery

L34413

In general, cataract surgery is performed to alleviate visual impairments attributable to lens opacity.

**“There are uncommon situations when lens extraction becomes medically necessary for anatomic reasons rather than optical reasons”**

**“These include induced angle closure (e.g. microspherophakia)”**

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## EMERGENCY VISIT

- IOP determined to be 30mmHg OD ad 32mmHg OS at a comprehensive eye examination
- What is the mechanism for elevated intraocular pressure?

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## What about the clonazepam?

**CONTRAINDICATIONS**

Klonopin should not be used in patients with a history of sensitivity to benzodiazepines, nor in patients with clinical or biochemical evidence of significant liver disease. It may be used in patients with open angle glaucoma who are receiving appropriate therapy but is contraindicated in acute narrow angle glaucoma.

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## Now what?


- Lower the pressure  
*Is this an acute emergency?*  
*Medical therapy is NOT disease-modifying*
- Arrange for cataract surgery?  
*How soon?*

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## Case #3

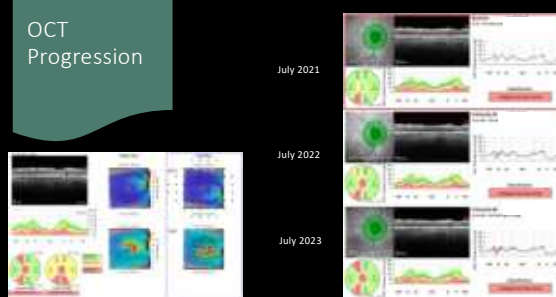
### Patient GM- Demographics & Entrance Testing

- New Glaucoma eval – patient had previous CEX
- GAT → 17, Tmax 26  
→ 18, Tmax 25
- Meds: Artificial tears, PGA qd OU, fixed combo bid OU
- PACH → 550  
→ 560
- C/D → 0.75v  
→ 0.80v
- Gonio: open to CB OU, mild pigment

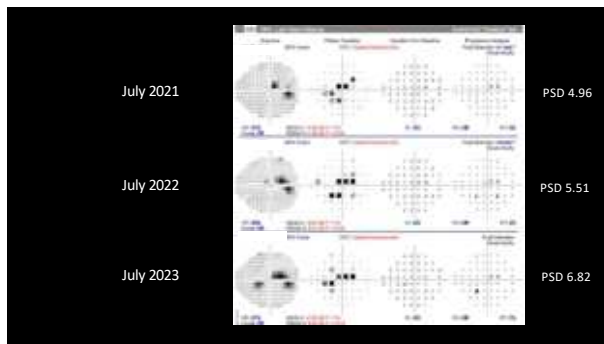


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## OCT Progression



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What Would You Do?

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**Case Summary:**

IOP @ 3 months: 15 mm Hg OD; 14 mm Hg OS  
No medications

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Trabecular Microbypass Stent (iStent Inject W)      Schlemm Canal Microstent (Hydrus)

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**Trabecular Microbypass Stent x 3**

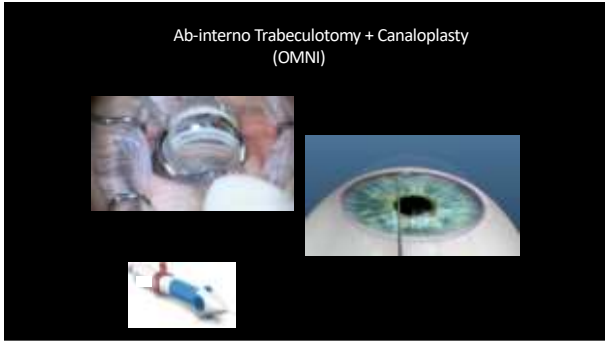
**Three-stent, standalone procedure**

Three wide-flange stents preloaded in injector system, to facilitate placement across ~6 clock hrs. of Schlemm's canal

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Excisional Goniotomy (Kahook Dual Blade)      Goniotomy (iAccess)      Goniotomy (SION)

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Xen 45 Gel Stent  
US Pivotal Clinical Trial

	Baseline	12 month
Medicated IOP	25.1 (3.7)	15.9 (5.2)
Glaucoma Meds	3.5 (1.0)	1.7 (1.5)

Hypotony 16 (24.6%)  
Bleb Needling 21 (32.3%)

Subconjunctival Stent (Xen)

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Post-operative Considerations with MIGS

1. Stopping GLC Meds
2. IOP Spikes
3. Hyphema
4. Hypotony
5. Establish New Baselines

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Stopping Glaucoma Medications

Severity of the Glaucoma

Preoperative IOP vs Postoperative IOP  
IOP progression was occurring

New baseline and hopefully off a med or meds

Likely on med in combo with MIGS

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PAS to Stents

US Pivotal iStent Inject Trial  
1.8% @ 24 months

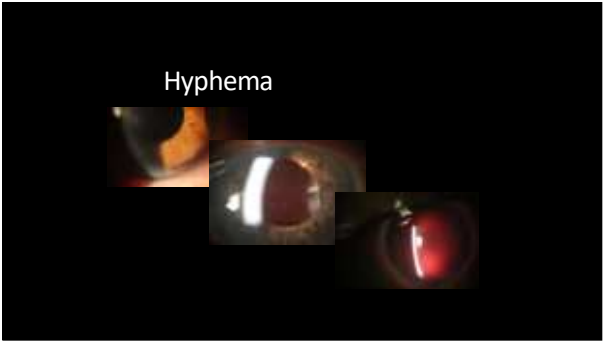
HORIZON Trial  
13% @ 48 months

YAG laser considered to open stent

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### Ocular Hypotony – Is it a Concern with MIGS?

Hypotony – An IOP below which the eye does not maintain its normal shape and may subsequently lose vision.  
Definitions vary slightly – IOP < 5 or 6

Episcleral Venous Pressure and its role

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#### STREAMLINING MEDICAL THERAPY

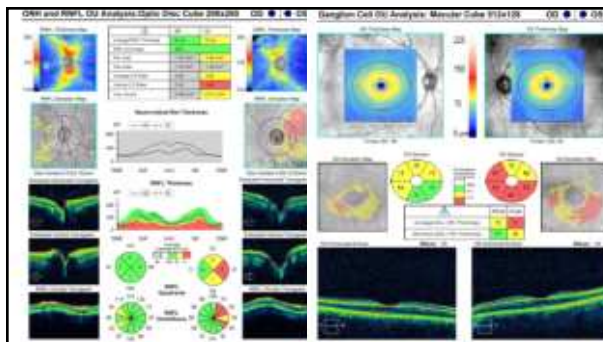
- 51 year old white male
- Diagnosis of pigmentary glaucoma left eye and pigment dispersion syndrome right eye
- Presents for second opinion; he is cautious about SLT—but wishes to “reduce medication load”
  - Significant dryness-failed on an immunomodulator and serum tears
- Non-Hodgkin’s lymphoma (2017), CMML (2023)
- History of bilateral LASIK
- Latanoprost QHS OU, dorzolamide-timolol BID OU, brimonidine BID OS
  - IOP 17mmHg OD, 21mmHg OS

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#### 51 YEAR OLD MALE

- Gonioscopy: open to CBB 360 degrees OD and OS
- 3+ dense Sampaolesi line right eye; 4+ dense Sampaolesi line left eye
- Flat iris approach
- Peak IOP 27mmHg OD 33mmHg OS

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### RHO KINASE

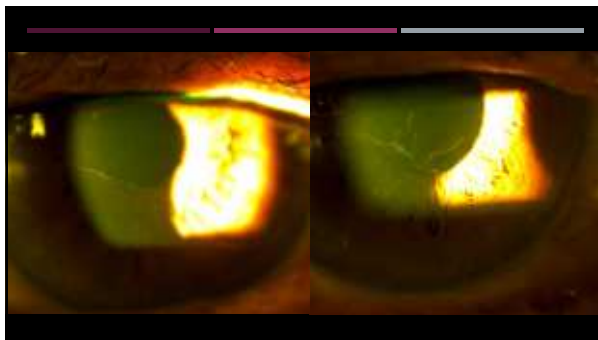
- Rho kinase family includes proteins which regulate cell shape, motility, proliferation, and apoptosis
- **Regulate smooth muscle contraction in the trabecular meshwork and ciliary body**
- *May also affect ocular blood flow and retinal ganglion cell survival*
- *Role in cardiovascular procedures, corneal procedures*
- *Role in development of fibrosis*

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### RHO KINASE INHIBITOR/NOREPINEPHRINE TRANSPORT INHIBITOR

- **Increase trabecular outflow**
- **Lower episcleral venous pressure**
- Netarsudil 0.02% (Rhopressa)
  - QHS
- Netarsudil/latanoprost 0.02%/0.005% (Rocklatan)
  - QHS
- Hyperemia-most common effect
  - Typically improves over time
  - *When do you see your patients back after altering medical therapy?*
- Subconjunctival hemorrhage
- Less common (in clinical trials)-**corneal verticillata**
  - Level of the epithelium


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### WHERE DO RHOPRESSA & ROCKLATAN FIT IN?

- Efficacy is similar to timolol 0.5% (BID)
  - *\*\*In clinical trials*
- Ideally a second line treatment
  - Seems to work better with low/moderate IOP (<25mmHg)
- Advantage of once daily dosing vs. other typical second line medication
- Cost?



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### MORE phase 4 trial

*Multicenter, prospective, open-label study  
No comparator; treated IOP =>20mmHg*

**Latanoprost, latanoprost + I, latanoprost +2**  
*Switch to netarsudil/latanoprost*

**Latanoprost** → -4.9mmHg  
**Latanoprost + I** → -3.6mmHg  
**Latanoprost +2** → -3.7mmHg

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**51 year old male**

**IOP check on netarsudil/latanoprost QHS  
OU for 16 days OU**

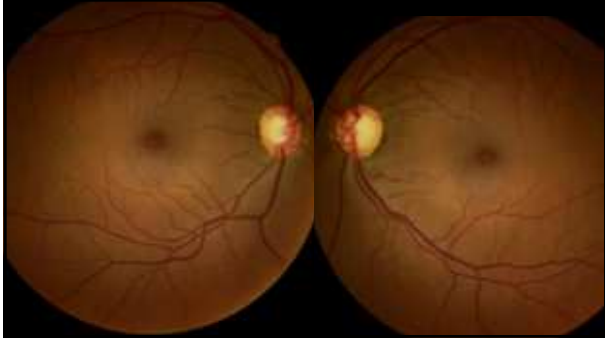
**IOP 15mmHg OD 21mmHg OS**

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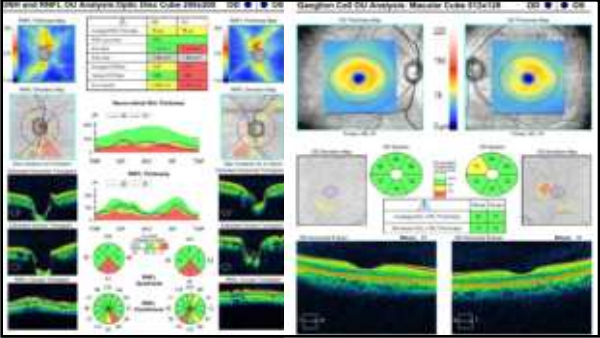
**48 YEAR OLD FEMALE**

- Recently relocated and presented to establish ongoing glaucoma care
  - POAG OU (diagnosed about 15 years ago)
    - Latanoprost QHS OU
    - Dorzolamide-timolol BID OU
    - Brimonidine BID OU
  - IOP 10mmHg OD and OS
  - CCT 477um/487um

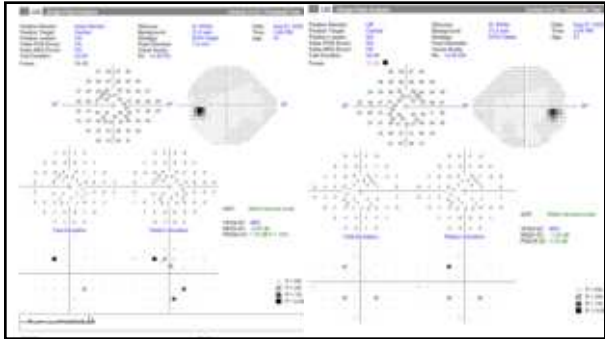
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**Is this glaucoma?**

**What are this patient's risk factors for development of glaucoma?**

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48 YEAR OLD FEMALE

- Now what?
  - Discontinue medication?
  - What is the risk of continuing therapy?

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## Discontinuation of therapy

*Step-wise, logical approach*

1. Stop dorzolamide-timolol  
IOP 15/15mmHg
2. Stop brimonidine  
IOP 17/18mmHg
3. Stop latanoprost  
IOP 29/28mmHg

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## Discontinuation of therapy

**4. Diagnose ocular hypertension**

**5. Restart latanoprost → switch to  
latanoprostene bunod 0.024%  
14mmHg OD 13mmHg OS**

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## Bottom line

**Set reasonable expectations for yourself**

*Of what someone can manage  
Of effectiveness of therapy  
Of the disease process*

**Individualize management.**

*Take the time that you need to establish a  
diagnosis, determine effectiveness of treatment,  
and determine progression*

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