

How an Interventional Mindset Transformed My Glaucoma Practice



CONTRIBUTOR

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Ten years ago, when I was training at Tulane, the tides were already turning in glaucoma management.

The first generation of MIGS had already come out, and the early clinical evidence was starting to show real promise. As a resident, I was one of the first to implant the iStent, so I had the chance to see something that stayed with me for years: patients who were finally able to discontinue or lower their glaucoma drops after the procedure. That experience planted a powerful seed.

We're in a different world, compared to previous generations, when it comes to glaucoma. When my father and grandfather were practicing, a glaucoma diagnosis was sort of a death sentence—a slow march towards eventual blindness.

For a long time, timolol was the only real treatment, and it was a sad sight to see. Eventually trabeculectomies and tube shunts became popular. But you're putting a hole in the eye. Unsurprisingly, patients want to avoid that as much as possible.

A lot of doctors were turned off going into glaucoma as a specialty—but recent advancements in interventional glaucoma have finally made it a much more attractive field.

We now have to be more bold and look at glaucoma more as a surgical than a medical condition.

Moving Beyond the Drops-First Paradigm

When I transitioned into private practice in Baton Rouge, the day-to-day realities—and flaws—of holding on to our old patterns quickly became apparent. Many of the problems have to do with adherence to topical medications. Patients would come to appointments proudly presenting their eyedrop bottles, but it didn't take long to notice the gaps. Many were using the wrong medication entirely—confusing the yellow cap with the pink cap, or even using a steroid or antibiotic instead of their prescribed glaucoma drop. I watched them miss their eyes completely during demonstrations. These weren't isolated incidents.

Over time, it became crystal clear to me that while drops certainly have their place as an arrow in our quiver. But now, there are more effective ways to attack this progressive disease and control the degeneration of sight.

We weren't doing our patients any favors by rigidly clinging to the old paradigm of starting with drops and then adding SLT only when necessary. The mounting evidence, combined with what I was seeing every day in the clinic, pushed me to make a deliberate shift: We needed to treat glaucoma more like a surgical disease than a purely medical one.

This meant stepping out of our comfort zone and being bolder with earlier intervention. Looking back, that mindset change was a crucial pivot to how our practice operates today.

Immediate Rewards for Patients and the Team

The first thing you notice when you go beyond conventional, drops-first paradigms is the happiness of the patients when you tell them they can reduce or even stop their medications. The sense of relief is immediate and genuine. Patients who've carried the load of chronic therapy for years show a sense of lightness that's easy to see.

The impact has extended far beyond the exam room. On the staff side, the transformation was equally visible. In the traditional model, they had to dedicate an hour or more every single day to handling callbacks related to glaucoma drops. These could be insurance coverage issues, pharmacies out of stock, or patients experiencing side effects. Those constant interruptions created a drag on the entire team.

Once we reduced the reliance on chronic drop therapy, our team suddenly spent a lot less time on those callbacks. Reducing the burden on the staff made them happier and more efficient, and morale goes a long way in the office.

Building an Interventional Culture

A key to our success was bringing the entire practice on board, not just the surgeons. We partnered with Glaukos to conduct a team-wide education session that helped everyone understand the “why” behind earlier intervention. Rather than a top-down change, this became a practice-wide philosophy.

For a while, we thought we were doing quite well with interventional treatment. However, we did a deep dive with a number of patients that qualify for some type of intervention versus the type of patients that actually received the treatment and uncovered the reality that a lot of glaucoma patients were falling through the cracks or being lost to follow-up. This opened our eyes to how we could better serve our patients.

Now, the process for a new glaucoma patient is much more streamlined and proactive. One of our 15 optometrists will usually make the initial diagnosis during routine visits. They know to start the patients on the topical medication, order a visual field test, and then refer the patient to a surgeon for evaluation when appropriate.

While insurance companies still require a trial of drops before approving procedural intervention, we now identify much earlier when that trial isn't working well. That could be due to inadequate

pressure control or intolerable side effects. We've seen a dramatic uptick in internal surgical referrals across our practice. Patients who might have fallen through the cracks are now getting the treatment they deserve.

Pre-op Counseling and Education

Our clinical team travels to our satellite branches to help train staff and arm them with the clear, consistent information they need for patient conversations. Now, MIGS conversations often start well before I get in the room. A typical early comment might sound like, “You didn't mention glaucoma in your history. The good news is there are a lot of excellent new tools available to address it now. The doctor may discuss some of these with you.” By the time I enter the room, patients are already primed and the discussion flows naturally.

One of the biggest surprises for me was how willing patients were to adopt interventional treatment. It's technically more surgery—yet another procedure—so I thought we'd have to hold patients' hands a bit longer to guide them. But I really haven't got much pushback. Patients understand, maybe sometimes more than doctors do, the benefit of something straightforward and safe to reduce medication burden. Offering MIGS at the same time as cataract surgery eases pressure on the patient. A confident surgeon's recommendation goes a long way, too.

Success Beyond IOP Numbers

Since leaning more heavily into interventional glaucoma, we've seen meaningful practice-level improvements. Visit cadence in our office is stable. We'll have post-op patients come in to check pressure at one week and one month. With MIGS, you can go 6 months after an acute post-op period if the IOP is stable.

There are benefits for us surgeons, too. Adding procedures like stents, one of the smallest medical implants in the human body, keeps things interesting and intellectually stimulating. I may do 40 cataract operations in a morning, so incorporating procedures like stents adds meaningful variety in the OR that keeps my skills sharp and my focus high while leading to reliable patient benefits.

A Patient Journey

One case that highlights how the whole practice now operates differently involves a patient with advanced glaucoma. It felt like we'd done everything we could for this patient. She'd had multiple MIGS procedures in the past, but the

disease continued to progress. I explained to her that glaucoma is like cancer. It's a progressive, degenerative disease that fights back.

This patient had horrible reactions to her drops: severe redness, unwanted attention from people staring at her and asking what was wrong with her eyes, vision disturbances, and so on. She was on two different medications, so we took her off them first to quiet the eye before any procedure, knowing her IOP would rise temporarily. Once the eye was stable, we scheduled a procedural pharmaceutical as the next step in her treatment.

The result was remarkable. We watched her IOP drop to the very low teens just from the one implant. It's truly amazing that we can put drugs inside the eye instead of outside the eye, where we have to consider compliance, adherence, and ocular surface disease.

This was her last chance before a trabeculectomy or a tube shunt. We were able to take her off all meds by month three, which is an incredibly pleasing result.

Stories like hers remind everyone in the practice why the interventional mindset matters: We now have better tools to stay ahead of glaucoma.

Practical Advice for Surgeons Ready to Make the Shift

If you're a colleague who's interested in becoming more interventional but are worried about disrupting your workflow, I have some good news. The transition ultimately improves efficiency and smooths out your workflow rather than upsetting it. You reduce the massive amount of time staff spend with refills, pharmacy calls, coverage issues, and adherence problems. Scheduling a procedure can save time in the long run.

Here are some good tips to consider:

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- 01 Start with one or two interventions you feel most comfortable performing. Many surgeons are already confident with SLT, so adding stents during cataract surgery is a logical progression.
 - 02 Remember: The best MIGS procedure is the one you perform the best.
 - 03 Before your first case, spend some time practicing on the surgical microscope with a gonio lens and viscoelastic.
 - 04 Partner closely with your chosen MIGS company on billing, coding, and patient identification so you understand exactly who qualifies and ensure you get reimbursed.

The Future I See

I think our practice will continue along this interventional path. Topical drops are transitioning from being a lifelong foundation therapy to more limited roles as bridge therapy or short-term rescue treatment. Insurance companies will hopefully come to recognize that earlier intervention can slow disease progression and reduce the eventual need for larger, more expensive surgeries.

The landscape today is entirely different than it was in previous decades. Rather than grim work, glaucoma care is becoming an exciting field packed with advances. More young surgeons are choosing glaucoma because they want to work with these safer, more effective treatments that improve patients' lives.

The support from the industry and overall growth in the sector is encouraging. Elegant stents, lasers, and sustained-delivery devices mean higher-quality care with less burden on both patients and clinical teams. Staying ahead of the disease rather than constantly chasing it is a future worth building.

*Dr. Williamson was compensated by Glaukos for his time in preparing this article.

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