

GREEK GLAUCOMA SOCIETY



28th 
Glaucoma
Congress

11-13 April 2024
Grand Bretagne Hotel

ΠΡΟΓΡΑΜΜΑ ΣΥΝΕΔΡΙΟΥ

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Το 28ο Συνέδριο Γλαυκώματος πιστοποιείται
από την Ευρωπαϊκή Εταιρεία Γλαυκώματος



ΓΕΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ

ΔΙΟΙΚΗΤΙΚΟ ΣΥΜΒΟΥΛΙΟ ΕΛΛΗΝΙΚΗΣ ΕΤΑΙΡΕΙΑΣ ΓΛΑΥΚΩΜΑΤΟΣ

Πρόεδρος:	Φ. Τοπούζης
Αντιπρόεδρος:	Ι. Χαλκιαδάκης
Γεν. Γραμματέας:	Ε. Καρμίρης
Ταμίας:	Σ. Κανδαράκης
Ειδ. Γραμματέας:	Θ. Φιλιππόπουλος
Μέλη:	Γ. Μαγκουρίτσας Δ. Παπακωνσταντίνου



ΕΛΛΗΝΙΚΗ ΕΤΑΙΡΕΙΑ ΓΛΑΥΚΩΜΑΤΟΣ

Π.Γ.Ν.Α., «Γ. Γεννηματάς» Παν/κή Οφθ/κή Κλινική,
Τμήμα Γλαυκώματος

Λεωφ. Μεσογείων 154, 11527 Αθήνα - Τηλ.: 210-72.29.091

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ΠΡΟΣΚΛΗΣΗ

Αγαπητοί συνάδελφοι,

Το Διοικητικό Συμβούλιο της Ελληνικής Εταιρείας Γλαυκώματος ανακοινώνει ότι το 28^ο Συνέδριο Γλαυκώματος θα πραγματοποιηθεί μεταξύ 11-13 Απριλίου 2024, στην Αθήνα.

Όπως κάθε χρόνο, η θεματολογία είναι εστιασμένη στην καθημερινή κλινική πράξη και πλαισιώνεται από έγκριτους ξένους και Έλληνες ομιλητές, που μέσα από διαλέξεις, κλινικά φροντιστήρια, συμπόσια, dry labs & στρογγυλά τραπέζια, θα μας ενημερώσουν για τις νεότερες εξελίξεις στον τομέα του Γλαυκώματος και πως η νέα γνώση μεταφράζεται και εφαρμόζεται στην καθημερινή κλινική πράξη.

Πιστεύουμε και ελπίζουμε στην ενεργό συμμετοχή σας για τη διεξαγωγή ενός επιτυχημένου συνεδρίου για μία ακόμη χρονιά.

Εκ μέρους του Δ.Σ. της Ελληνικής Εταιρείας Γλαυκώματος

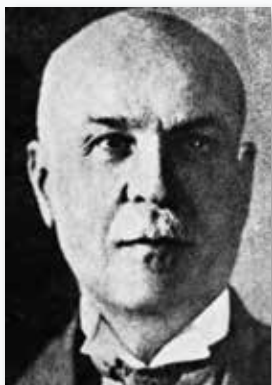
Ο Πρόεδρος
Φώτης Τοπούζης



ΑΝΔΡΕΑΣ ΑΝΑΓΝΩΣΤΑΚΗΣ (1826-1897)

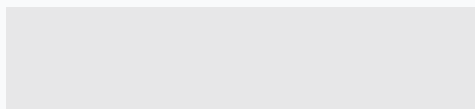
Ο Ανδρέας Αναγνωστάκης υπήρξε ο πρώτος Καθηγητής Οφθαλμολογίας στην Ιατρική Σχολή του Εθνικού Πανεπιστημίου Αθηνών (1856) έως και 41 χρόνια αργότερα. Το 1854 δημοσίευσε ένα άρθρο στα γαλλικά (*Essai sur l'exploration*

de la rétine et des milieux de l'oeil sur le vivant, au moyen d'un nouvel ophthalmoscope), στο οποίο περιέγραψε την εφεύρεση ενός απλουστευμένου οφθαλμοσκοπίου, που χρησιμοποιούσε μόνο ένα διάτρητο κοίλο κάτοπτρο. Αυτή ήταν η πρώτη εργασία στα γαλλικά για το οφθαλμοσκόπιο και είχε μεγάλη απήχηση στον οφθαλμολογικό κόσμο εάν λάβουμε υπόψη μας ότι το δικό του οφθαλμοσκόπιο πουλήθηκε σε 800 οφθαλμιάτρους μέσα σε λίγους μήνες. Οι αριθμοί αυτοί είναι εξαιρετικά μεγάλοι για την εποχή εκείνη, ιδίως λόγω του γεγονότος ότι το πρώτο οφθαλμοσκόπιο είχε εισαχθεί μόλις τρία χρόνια πριν από την τροποποίηση του Αναγνωστάκη από τον Hermann von Helmholtz.



ΑΛΕΞΙΟΣ ΤΡΑΝΤΑΣ (1867-1961)

Το 1899 ο οφθαλμίατρος Αλέξιος Τράντας κατάφερε να παρατηρήσει in vivo τη γωνία του προσθίου θαλάμου σε ένα μάτι με μεγακερατοειδή, χρησιμοποιώντας άμεση οφθαλμοσκόπηση σε συνδυασμό με δακτυλική πίεση στο σκληροκερατοειδές όριο. Ήταν ο πρώτος που χρησιμοποίησε τον όρο «γωνιοσκοπία» και το 1900 περιέγραψε την εικόνα της γωνίας φυσιολογικής και μη, σημειώνοντας περιπτώσεις πυκνής χρώσης του διηθητικού ηθμού, ιριδικών προβολών και κυκλοδιάλυσης. Σχεδόν επί δύο δεκαετίες, ο Τράντας κατέγραφε πολύτιμες κλινικές παρατηρήσεις σχετικά με την εμφάνιση της γωνίας σε διάφορες παθήσεις, με αποτέλεσμα να αναγνωρισθεί το 1948 από την Βελγική Οφθαλμολογική Εταιρεία ως «πατέρας της γωνιοσκοπίας». Επίσης περιέγραψε τις υποκίτρινες εναποθέσεις του επιπεφυκότα πέριξ του σκληροκερατοειδούς ορίου ως παθογνωμονικές της εαρινής αλλεργικής επιπεφυκίτιδας, γνωστές μέχρι και σήμερα ως κηλίδες του Τράντα.





ΠΛΗΡΟΦΟΡΙΕΣ ΕΓΓΡΑΦΗΣ

ΚΑΤΗΓΟΡΙΑ	ΚΟΣΤΟΣ
ΕΙΔΙΚΟΙ ΟΦΘΑΛΜΙΑΤΡΟΙ	150 €
ΕΙΔΙΚΕΥΜΕΝΟΙ ΟΦΘΑΛΜΙΑΤΡΟΙ (μέσω εταιρειών ΣΦΕΕ)	120 €
ΕΙΔΙΚΕΥΟΜΕΝΟΙ ΟΦΘΑΛΜΙΑΤΡΟΙ	70 €
ΝΟΣΗΛΕΥΤΕΣ, ΦΟΙΤΗΤΕΣ	ΔΩΡΕΑΝ

* Η εγγραφή δεν περιλαμβάνει επισιτιστικές υπηρεσίες.

ΚΟΣΤΟΣ ΕΠΙΣΙΤΙΣΤΙΚΩΝ: 30,00 ευρώ.

Η συμμετοχή στο Συνέδριο για τους Ε.Υ. (Επαγγελματίες Υγείας) περιλαμβάνει δυνατότητα παρακολούθησης του επιστημονικού προγράμματος, παραλαβή συνεδριακού υλικού, είσοδο στην έκθεση, συμμετοχή στις κοινωνικές εκδηλώσεις του Συνεδρίου και παραλαβή του ηλεκτρονικού πιστοποιητικού συμμετοχής, βάσει των ωρών παρακολούθησης.

Για νοσηλευτές και προπτυχιακούς φοιτητές / νοσηλευτές, η συμμετοχή στο Συνέδριο είναι δωρεάν και περιλαμβάνει δυνατότητα παρακολούθησης του επιστημονικού προγράμματος, είσοδο στην έκθεση, και απλή βεβαίωση συμμετοχής. Η ιδιότητα τους ωστόσο, θα πρέπει να βεβαιώνεται από επίσημο φορέα που μπορεί να πιστοποιήσει την ιδιότητα τους (π.χ. επιστολή από τον διευθυντή της κλινικής για τους νοσηλευτές)

Καθ' όλη τη διάρκεια του Συνεδρίου θα υπάρχει μετάφραση των ομιλιών, καθώς και σύστημα ηλεκτρονικής καταμέτρησης των ωρών παρακολούθησης του προγράμματος. Το Συνέδριο μοριοδοτείται με μόρια συνεχιζόμενης εκπαίδευσης, και η παραλαβή του πιστοποιητικού προϋποθέτει τη συμπλήρωση -ηλεκτρονικά- του ανώνυμου εντύπου αξιολόγησης και την παρακολούθηση του 60% των ωρών του επιστημονικού προγράμματος, κατ' ελάχιστον.

ΤΡΟΠΟΙ ΠΛΗΡΩΜΗΣ

Έως το συνέδριο: Κατάθεση ποσού στην Εθνική Τράπεζα της Ελλάδος

ΕΛΛΗΝΙΚΗ ΕΤΑΙΡΕΙΑ ΓΛΑΥΚΩΜΑΤΟΣ

Αριθμός Λογαριασμού 169/629649-18 IBAN Νο GR8701101690000016962964918

αναφέροντας ονοματεπώνυμο και ιδιότητα συνέδρου (ειδικευμένος / ειδικευόμενος)

Κατά τη διάρκεια του συνεδρίου: Πληρωμή στη γραμματεία των εγγραφών

ΓΡΑΜΜΑΤΕΙΑ ΣΥΝΕΔΡΙΟΥ

Η Γραμματεία θα λειτουργεί καθ' όλη τη διάρκεια του συνεδρίου, τις ακόλουθες ώρες:

ΠΕΜΠΤΗ 11/04/2024: 13.00 - 19.30

ΠΑΡΑΣΚΕΥΗ 12/04/2024: 09.00 - 19.30

ΣΑΒΒΑΤΟ 13/04/2024: 09.00 - 19.00

ΣΥΝΕΔΡΙΑΚΕΣ ΑΙΘΟΥΣΕΣ & ΧΩΡΟΣ ΕΚΘΕΣΗΣ

11 Απριλίου 2024

Το συνέδριο θα πραγματοποιηθεί στον ημιόροφο του Ξενοδοχείου KING GEORGE.

12 Απριλίου - 13 Απριλίου 2024

Το συνέδριο θα πραγματοποιηθεί στις αίθουσες του Ξενοδοχείου ΜΕΓΑΛΗ ΒΡΕΤΑΝΙΑ.

Ο χώρος έκθεσης των εταιρειών του κλάδου, θα λειτουργήσει σε παράπλευρες αίθουσες της συνεδριακής, στο Ξενοδοχείο ΜΕΓΑΛΗ ΒΡΕΤΑΝΙΑ.

ΔΙΑΜΟΝΗ ΣΥΝΕΔΡΩΝ - ΠΛΗΡΟΦΟΡΙΕΣ ΚΡΑΤΗΣΗΣ ΔΩΜΑΤΙΩΝ

Επισημαίνεται ότι κρατήσεις δωματίων για τους συνέδρους στο Ξενοδοχείο ΜΕΓΑΛΗ ΒΡΕΤΑΝΙΑ δεν γίνονται, καθώς χρησιμοποιείται μόνο ως χώρος διεξαγωγής του συνεδρίου.

Οι ενδιαφερόμενες εταιρείες θα πρέπει να μεριμνήσουν σχετικά, σε άλλα ξενοδοχεία, λαμβάνοντας υπόψη ότι το κόστος φιλοξενίας (διαμονή και διατροφή) των επαγγελματιών υγείας δεν μπορεί να υπερβαίνει τα ποσά που ορίζουν οι επικαιροποιημένες εγκύκλιοι ΕΟΦ και ΣΦΕΕ.



ΕΠΙΣΤΗΜΟΝΙΚΟ ΠΡΟΓΡΑΜΜΑ



ΠΕΜΠΤΗ 11 ΑΠΡΙΛΙΟΥ 2024

13.30-19.00 ΕΓΓΡΑΦΕΣ ΣΥΝΕΔΡΩΝ

ΑΙΘΟΥΣΑ Α' - ΚΛΙΝΙΚΑ ΦΡΟΝΤΙΣΤΗΡΙΑ

14.30-16.00 Μικρά Καθημερινά Διλήμματα στην Κλινική Πράξη

Συντονιστής: Γ. Κίτσος

Σχολιαστές: Ε. Αναστασόπουλος, Α. Βέργαδος, Γ. Δαλιάνης, Σ. Τσιρώνη

Ποιος είναι ο ιδανικός ασθενής για SLT;

Δ. Μπεσίνης

Πώς παρακολουθώ τον ασθενή με αναξιόπιστα οπτικά πεδία;

Α. Μάνδαλος

Πότε η σταθερότητα στο OCT δημιουργεί ψευδή εξασφάλιση;

Δ. Τσουκανάς

Πότε ο ασθενής χρειάζεται τραμπεκτιουλεκτομή;

Α. Δαστιρίδου

Ποιος ασθενής χρειάζεται καμπύλη πίεσης;

Β. Τζίμης

Οι ασθενείς με γλαύκωμα χαμηλής πίεσης χρειάζονται όλοι νευροαπεικονιστικό έλεγχο;

Μ. Γεωργόπουλος

Μπορώ να επιλέξω πολυεστιακό ενδοφακό ή ενδοφακό EDOF σε ασθενείς με γλαύκωμα;

Δ. Αλωνιστιώτης

16.00-16.30 ΔΙΑΛΕΙΜΜΑ

16.30-18.00 Sub-specialty Training after Residency: The European Glaucoma Society (EGS) Glaucoma Fellowship Program
Εκπαίδευση Υπό-Εξειδίκευσης μετά την Ειδικότητα:
Το Πρόγραμμα Υπό-Εξειδίκευσης στο Γλαύκωμα της Ευρωπαϊκής Εταιρείας Γλαυκώματος (EGS)

Συντονιστές:

G. Sunaric-Mégevand, F. Topouzis

The EGS Europe-Wide Glaucoma Fellowship Project. The Future of Glaucoma Care in Europe.

G. Sunaric-Mégevand

The Glaucoma Clinical Fellowship Experience in the UK.

P. Founti

The Value of a Glaucoma Research Fellowship.

A. Dastiridou

Why a Fellowship? Preparing Yourself for Competitive CV, Submission & Interview.

E. Papakonstantinou

The EGS Glaucoma Fellowship in Greece: Expectations and Experience so Far.

P. Ntonti

18.00-20.00 **CASE REPORT COMPETITION ΣΕ ΜΝΗΜΗ Α. ΔΙΑΓΟΥΡΤΑ**

Παρουσίαση Εργασιών από Ειδικευόμενους

Συντονιστές:

Φ. Τοπούζης, Δ. Παπακωνσταντίνου

ΑΙΘΟΥΣΑ Β' - DRY LABS

14.00-19.30 **Εκπαιδευτικό Φροντιστήριο**

Επιστημονικός υπεύθυνος: **Δ. Παπακωνσταντίνου**

Θεματολογία:

**Introduction-Theory / Opening the conjunctiva
Creating a flap / Sclerostomy / Flap suturing /
Conjunctiva Suturing**

Εκπαιδευτές: Δ. Αλωνιστιώτης, Ε. Αναστασόπουλος, Α. Βέργαδος, Μ. Γεωργόπουλος, Δ. Γιαννούλης, Α. Δαστιρίδου, Α. Δημάκης, Σ. Κανδαράκης, Ε. Καρμίρης, Α. Καρύδης, Γ. Κοψίνης, Δ. Κουρκούτας, Α. Μάνδαλος, Δ. Μπεσίνης, Π. Ντόντη, Ε. Παπακωνσταντίνου, Χ. Παππά, Β. Τζίμης, Γ. Τομαής, Δ. Τσουκανάς, Θ. Φιλιππόπουλος, Ι. Χαλκιαδάκης

14.00-14.30 **Εισαγωγή - Θεωρητικό μάθημα**

Ομιλητής: Ι. Χαλκιαδάκης

14.30-19.30 **Πρακτικό σκέλος** (αλφαβητικά)

14.30-15.45 **ΟΜΑΔΑ 1** - Ε. Καρμίρης, Α. Καρύδης, Π. Ντόντη, Ε. Παπακωνσταντίνου, Χ. Παππά

15.45-17.00 **ΟΜΑΔΑ 2** - Ε. Αναστασόπουλος, Σ. Κανδαράκης, Γ. Κοψίνης, Δ. Κουρκούτας, Θ. Φιλιππόπουλος

17.00-18.15 **ΟΜΑΔΑ 3** - Δ. Αλωνιστιώτης, Δ. Γιαννούλης, Α. Δημάκης, Β. Τζίμης, Γ. Τομαής

18.15-19.30 **ΟΜΑΔΑ 4** - Α. Βέργαδος, Α. Δαστιρίδου, Α. Μάνδαλος, Δ. Μπεσίνης, Δ. Τσουκανάς



ΠΑΡΑΣΚΕΥΗ 12 ΑΠΡΙΛΙΟΥ 2024

09.00

ΕΓΓΡΑΦΕΣ

09.30-09.45 **ΕΠΙΣΗΜΗ ΕΝΑΡΞΗ** - Χαιρετισμός Προέδρου

09.45-10.00 **ΒΡΑΒΕΥΣΗ Ν. ΜΥΛΟΠΟΥΛΟΥ**

10.00-11.00 **ΣΤΡΟΓΓΥΛΟ ΤΡΑΠΕΖΙ**

Συντονιστές: Δ. Παπακωνσταντίνου & Χ. Τερζίδου

Θέμα: **Γλαυκωματικά Διλήμματα στην καθημερινότητα του οφθαλμιάτρου**

Συμμετέχοντες: **Α. Βέργαδος, Δ. Γιαννούλης, Ε. Καρμίρης, Π. Παπαπάνος**

11.00-12.00 **ΔΙΑΛΕΞΕΙΣ**

Προεδρείο: **Ι. Χαλκιαδάκης, Ν. Μυλόπουλος**

Ενότητα: **Dilemmas in Glaucoma**

Patients with Early Disease. Implications of Overdiagnosis in Glaucoma.

A. Tatham

The Central Visual Field in Glaucoma. Which Testing Strategy is Most Efficient;

A. Viswanathan

Diagnostic Challenges in Myopic Patients.

A. Tatham

Personalized Guidance Regarding Lifestyle Changes in Glaucoma Patients.

A. Bron

12.00-12.30

ΔΙΑΛΕΙΜΜΑ

12.30-13.30

ΔΙΑΛΕΞΕΙΣ

Προεδρείο:

Θ. Φιλιππόπουλος, Σ. Γιαννικάκης

Ενότητα:

Angle Closure Glaucoma

Primary Angle Closure Disease. Should we Even Care in Western Societies?

A. Khawaja

Anterior Segment Imaging in Primary Angle Closure Disease. Does it Alter Clinical Management?

G. Mégevand-Sunaric

The Role of LPI and Clear Lens Extraction in Primary Angle Closure Disease.

G. Gazzard

Is Secondary Angle Closure a Different Disease Entity?

P. Founti

13.30-15.00

ΓΕΥΜΑ

15.00-16.00

ΔΟΥΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ

(βλ. τέλος επιστημονικού προγράμματος)

16.00-17.00

ΣΤΡΟΓΓΥΛΟ ΤΡΑΠΕΖΙ

Συντονιστές:

A. Κώνστας & B. Κοζομπόλης

Θέμα:

Στοχευμένη Διάγνωση και Αντιμετώπιση του Γλαυκώματος Κλειστής Γωνίας

Συμμετέχοντες:

E. Δετοράκης, A. Κατσάνος, Δ. Μικρόπουλος, Θ. Φιλιππόπουλος

17.00-17.15

ΔΙΑΛΕΙΜΜΑ

17.15-18.15

ΔΙΑΛΕΞΕΙΣ

Προεδρείο:

B. Κοζομπόλης, E. Αναστασόπουλος

Ενότητα:

**Glaucoma in Other Subspecialty Fields
and in Special Conditions**

Refractive Considerations & Intraocular Lens Selection
in Glaucoma Patients Undergoing Cataract Surgery.

J. Garcia-Feijoo

Management of Glaucoma in Patients with Uveitis.

K. Barton

Management of Glaucoma in Patients with Retinal Pathology.

N. Pfeiffer

The 9 months and Beyond Dilemma: Glaucoma in Pregnancy
and Lactation.

I. Stalmans

18.15-19.15

ΔΙΑΛΕΞΕΙΣ

Προεδρείο:

A. Κανδαράκης, E. Καρμύρης

Ενότητα:

**Dilemmas in Patients with Advanced Glaucoma.
How not to Miss Progression in Advanced Disease?**

A. Viswanathan

Identifying Subsets of Patient in Need for more
Aggressive Treatment.

G. Sunaric-Mégevand

Every Detail Matters: The Role of Blood Pressure and Systemic
Medications in Assessing Glaucoma Risk and in the Management
of the Patient with Advanced Disease.

A. Khawaja

The First Step is the Best Step. What is the Best First Line
Treatment for Patients with Advanced Glaucoma?

I. Stalmans



ΣΑΒΒΑΤΟ 13 ΑΠΡΙΛΙΟΥ 2024

09.30-10.30 ΣΤΡΟΓΓΥΛΟ ΤΡΑΠΕΖΙ

Συντονιστής: **Φ. Τοπούζης & Α. Κασάνος**

Θέμα: **Κίνδυνοι στο Γλαύκωμα**

Συμμετέχοντες: **Ε. Αναστασόπουλος, Δ. Γιαννούλης, Α. Κασάνος, Π. Ντόντη, Ε. Παπακωνσταντίνου**

10.30-11.30 ΔΙΑΛΕΞΕΙΣ

Προεδρείο: **Α. Κώνστας, Α. Κασάνος**

Ενότητα: **Diagnosis & Progression Challenges**

Testing in Glaucoma. When to do More and When to do Less?

L. Rossetti

Which are the most Important Biomarkers to Determine and Predict Progression in Glaucoma?

R. N. Weinreb

How much Vision Change is Clinically Significant and What Defines Fast-Progressors?

S. Miglior

11.30-12.00 ΔΙΑΛΕΙΜΜΑ

12.00-13.00 ΔΟΥΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ

(βλ. τέλος επιστημονικού προγράμματος)

13.00-14.30 ΔΙΑΛΕΞΕΙΣ

Προεδρείο: Φ. Τοπούζης, Δ. Παπακωνσταντίνου

Ενότητα: [The Evolution in the Field of Glaucoma](#)

What do I do Differently Compared to 10 Years ago?

L. Rossetti

Twenty Years after Launching the Landmark Studies

OHTS, EMGT, and EGPS.

What have we Learned?

S. Miglior

«ANAGNOSTAKIS -TRANTAS» Award

Honorary Lecture: *Τα πάντα ρέει και οὐδὲν μένει*

R. N. Weinreb

14.30-15.30 ΓΕΥΜΑ

15.30-16.30 ΔΟΥΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ

(βλ. τέλος επιστημονικού προγράμματος)

16.45-18.15 ΔΙΑΛΕΞΕΙΣ

Προεδρείο: Γ. Μαγκουρίτσας, Σ. Κανδαράκης

Ενότητα: [Common Puzzles in the Surgical Approach of Glaucoma](#)

When is the Time for Surgery and How can I Convince my Patients to Undergo Surgery?

N. Pfeiffer

Threat to Fixation: Does it Alter my Go To Procedure?

A. Bron

My Go To MIGS Procedure and my Expectations for the Future.

K. Barton

What are the Options after Failed Trabecular MIGS and Bleb Forming Devices Procedures?

G. Gazzard

Sustained Drug Delivery Devices. Are they Getting Ready for Prime-Time?

T. Patrianakos

Optic Nerve Head and Endothelium. How to Preserve both after Filtration Surgery?

J. Garcia-Feijoo

18.15-19.15 **ΣΤΡΟΓΓΥΛΟ ΤΡΑΠΕΖΙ**

Συντονιστές: **Γ. Μαγκουρίτσας & Ι. Χαλκιαδάκης**

Θέμα: **Επίκαιρες αντιπαραθέσεις στην αντιμετώπιση του Γλαυκώματος**

Κλειστή γωνία: Αντιμετώπιση με περιφερική ιριδεκτομή ή με εξαίρεση του φακού;

Γ. Κοψίνης, Θ. Φιλιππόπουλος

Φακοθρυψία σε καλώς ελεγχόμενο Γλαύκωμα:

Είναι απαραίτητα τα MIGS;

Γ. Δαλιάνης, Δ. Μπεσίνης

Γλαύκωμα τελικού σταδίου: Συντηρητική θεραπεία

ή άμεση χειρουργική αντιμετώπιση;

Χ. Παππά, Β. Τζίμης

19.15-19.30 **ΑΠΟΝΟΜΗ ΒΡΑΒΕΙΟΥ CASE REPORT Α. ΔΙΑΓΟΥΡΤΑ**

19.30 **ΛΗΞΗ ΣΥΝΕΔΡΙΟΥ**



ΕΤΑΙΡΙΚΕΣ ΕΚΔΗΛΩΣΕΙΣ

ΣΥΜΠΟΣΙΑ

ΠΑΡΑΣΚΕΥΗ 12 ΑΠΡΙΛΙΟΥ 2024

15.00-16.00 ΔΟΥΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ



Θέμα: Στοχεύοντας στη βελτιστοποίηση της αντιμετώπισης του Γλαυκώματος στον 21^ο αιώνα

Συντονιστής: Α. Κώνστας

Συμμετέχοντες: Α. Κατσάνος, Κ. Μπομπορίδης, Φ. Τοπούζης

12.00-13.00 ΔΟΥΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ



Θέμα: Match your management to your patient

Συντονιστής: Φ. Τοπούζης

Συμμετέχοντες: Ε. Αναστασόπουλος, Ι. Χαλκιαδάκης, Κ. Μπομπορίδης,
Σ. Κανδαράκης

15.45-16.45 ΔΟΥΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ



Θέμα: What has changed and what is changing?

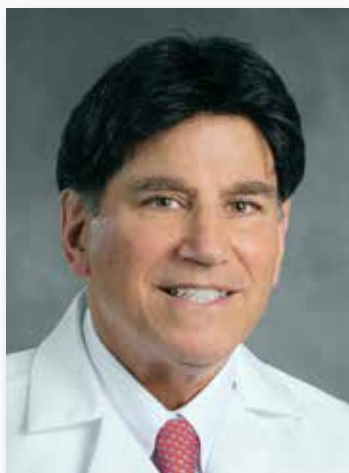
Προεδρείο: Χ. Τερζίδου

Συμμετέχοντες: Γ. Μαγκουρίτσας, Θ. Πατριανάκος



«ANAGNOSTAKIS -TRANTAS» AWARD

RECIPIENT 2024



**«ANAGNOSTAKIS -TRANTAS» Award
R. N. Weinreb**

**Director, Shiley Eye Institute
Distinguished Professor
and Chair of Ophthalmology
Distinguished Professor of Bioengineering
Morris Gleich MD Chair of Glaucoma
Director, Hamilton Glaucoma Center
Founding Faculty,
Halicloglu Data Science Institute
University of California San Diego**

Robert N. Weinreb, M.D. is the Chair and Distinguished Professor of Ophthalmology at the University of California, San Diego as well as Director of both the Shiley Eye Institute and Hamilton Glaucoma Center. He holds the Morris Gleich MD Chair of Glaucoma and also is appointed as Distinguished Professor of Bioengineering. Dr. Weinreb graduated top of his class in both Mathematics and Electrical Engineering from the Massachusetts Institute of Technology. He then obtained his MD degree from Harvard Medical School where he was elected President of the Boylston Society, the medical student honor society.

A clinician, a surgeon and a scientist, Dr. Weinreb oversees all clinical activities at the Shiley Eye Institute and within the Department of Ophthalmology. As the Director of the Hamilton Glaucoma Center, he also oversees a renowned multi-disciplinary team of scientists and staff dedicated to glaucoma.

The recipient of numerous national/ international awards and prizes, Dr. Weinreb's research interests are diverse and range from the front to the back of the eye. Focused on glaucoma and the optic nerve, they include imaging, mechanisms of optic nerve damage, and neuro-protection. He also studies aqueous outflow, particularly within the uveoscleral outflow pathway, has developed implantable intraocular pressure sensors and invented flexible

electronic devices for medication adherence. Further, Dr. Weinreb has a keen interest in improving the efficacy and safety of glaucoma surgery.

Dr. Weinreb has delivered 155 named lectures throughout the world. In 2023, he was named by *The Ophthalmologist* as one of the TOP 2 most influential ophthalmologists in the world. In 2024, he was an inaugural inductee to the *Ophthalmologist Hall of Fame, Honoree at the Annual Meeting of the American Glaucoma Society and also named as one of 24 World EyeCons* by the Asian-Pacific Journal of Ophthalmology honoring the most influential ophthalmologists globally who help shape the world of Ophthalmology in the 21st century.

Mentoring of clinical and research fellows in glaucoma has been a career passion. Twenty six of his trainees have become department chairs in the United States and around the world; numerous others are professors or have excelled as leaders in practice in their communities or industry.

As a former president of the Association for Research in Vision and Ophthalmology (ARVO), American Glaucoma Society, World Glaucoma Association, Foundation of the American Glaucoma Society, and Latin American Glaucoma Society, Dr. Weinreb is dedicated to improving educational opportunities and outreach of some leading organizations. He is a co-Founder (with Roger Hitchings and Erik Greve) of the World Glaucoma Association and serves as Chief Editor of the *International Glaucoma Review*.



ΞΕΝΟΙ ΠΡΟΣΚΕΚΛΗΜΕΝΟΙ

ΠΕΡΙΛΗΨΕΙΣ



Keith Barton, MD FRCP FRCS
Professor of Ophthalmology,
University College London
Consultant Ophthalmic Surgeon

Management of Glaucoma in Patients with Uveitis

The management of uveitic glaucoma differs from other primary and secondary glaucomas. The mechanism of IOP elevation may be the result of a mixture of both treatment and disease. The angle may be open or closed and even angle closure mechanisms differ. The disease may elevate or reduce the pressure, as may the treatment. Patients are much younger, on average than other types of glaucoma.

As a result, the extremes of intraocular pressure are greater, the degree of necessary treatment aggression is also greater, often resorting to more aggressive earlier surgical intervention.

In this talk I will outline the issues and some general principles, detailing aspects of surgical and medical management specifically for patients with uveitic glaucoma and how these must be balanced against the need to prevent further inflammatory damage from ongoing uveitis.

My Go To MIGS Procedure and my Expectations for the Future

In this world of proliferating surgical options for glaucoma, it is easy to get bamboozled by the options and lose perspective. MIGS and less invasive surgical treatments break down largely into the very crowded canal space with a number of stenting, cutting and dilating options. Subconjunctival space and suprachoroidal-supraciliary space treatments have been explored less enthusiastically by industry because of the challenges of fibrosis, failure and the need for longer postoperative care. In this talk I will discuss my preferences in different surgical situations and explain the rationale coupled with real world data across the spectrum of the newer glaucoma surgical treatments that we have collected over the past 6 years using the International Glaucoma Surgery Registry.



Bron Alain, MD

Professor of Ophthalmology,
University Hospital,
Dijon, France

Threat to fixation: Does it alter my go to procedure?

Visual defects close to the fovea are generally considered in textbooks as a threat to post-operative visual acuity when a surgical procedure for glaucoma is planned. Indeed, the so controversial wipe-out syndrome has been reported with postoperative hypotony and the para foveal location of visual field defects.

Recent literature is shedding a different light on the impact of function alterations with a more positive view. Through a recent survey of glaucoma specialists, we will discuss that the surgical go to procedure is most often chosen accordingly to the personal preferences of the surgeons and their conflicts of interest but not really upon the location of visual damage.

Personalized Guidance Regarding Lifestyle Changes in Glaucoma Patients

For clinicians it is common to have questions engaging glaucoma patients in a personal effort for specific food, diets, exercise, meditation etc. This demand is legitimate brings a good opportunity to educate our patients about glaucoma.

Conversely to other ocular diseases such as AMD, there is no robust recommendations to give to our glaucoma patients. Most of the information regarding lifestyle and glaucoma is confusing for two main causes.

First, we have only observational studies and not interventional studies on lifestyle, and an association does not mean causality. Second most of these abrupt recommendations come from companies, individuals, doctors with the combined pollution of beliefs and business.



Prof. Dr. Julian Garcia-Feijoo, MD
Professor and Chairman Department
of Ophthalmology Universidad Complutense,
Hospital Clinico San Carlos, Madrid, Spain

Refractive Considerations & Intraocular Lens Selection in Glaucoma Patients Undergoing Cataract Surgery

Glaucoma and cataract are two diseases whose prevalence increases with age so cataract surgery should be undertaken in the majority of glaucomatous patients. It is crucial to properly plan lens surgery in the context of glaucomatous disease.

A key aspect is the management of the patient's refractive expectations and the selection of the most appropriate intraocular lens.

Although multifocal lenses are a very interesting alternative in patients with cataract without other coexisting pathologies, they are not recommended in patients with glaucomatous damage and should be used with caution even in low-risk ocular hypertensive patients. It must be remembered that this type of IOLs is associated with some visual problems and specifically a decrease in contrast sensitivity. Furthermore, in my opinion they should not be used in any case of pseudoexfoliation or PSX glaucoma. Other options (toric and monofocal plus lenses...) will be discussed in the presentation.

In summary,

1. It must be explained in detail and the patient must understand the real expectation of visual recovery according to the pre-existing glaucomatous damage.

2. Given the unpredictability of the evolution of glaucoma, in general, the use of multi-focal lenses is not recommended in patients with glaucoma.
3. In patients with ocular hypertension, factors such as additional risk factors for glaucoma progression, age, life expectancy and preoperative contrast sensitivity must be assessed

Optic Nerve Head and Endothelium. How to Preserve Both After Filtration Surgery?

The aim of glaucoma surgery is the preservation of vision, slowing the progression of damage to the nerve fibres of the ganglion cells to preserve visual function. Surgery offers advantages to achieve this goal, in most cases a lower and more stable IOP is achieved (with or without additional medical treatment). On the other hand, filtering surgery has associated risks, which must be considered to adapt the indication to the risk-benefit profile of each patient. If we focus on the corneal endothelium, the endothelial repercussion of conventional filtering surgery is known, but it should not be forgotten that chronic medical treatment also has a negative impact on the corneal endothelium and that many patients have previously undergone phacoemulsification. A careful technique to avoid problems such as postoperative hypotonia and especially corneal-iris contact is key to minimizing endothelial damage. Finally, in recent years, surgeries with bleb forming devices (LIGS, MIBS or MPEGS...) have been widely adopted, in these cases the proper positioning of the device is crucial, since possible relevant endothelial damage in the future will depend mainly on its position.



Dr Panayiota Founti PhD, FEBO (Hons)

Consultant Ophthalmic Surgeon
& Training Director, Glaucoma Service
Moorfields Eye Hospital, London, UK
Honorary Senior Research Associate
UCL Institute of Ophthalmology, London, UK

The Clinical Glaucoma Fellowship Experience in the UK

A clinical glaucoma fellowship in the UK focuses predominantly on advanced medical and surgical training, and therefore is an important step towards a specialised career in glaucoma.

However, the experience of this training may vary a lot depending on the institution or even between clinicians enrolled in the same fellowship programme.

This presentation will discuss the journey through a clinical glaucoma fellowship in the UK and associated factors in this experience, including the ‘preparatory’ years before the fellowship, as well as the career opportunities that this training can provide.

Is Secondary Angle Closure a Different Disease Entity?

Angle closure is characterized by appositional or synechial closure of the anterior chamber angle. As opposed to primary angle closure, which affects anatomically pre-disposed individuals, secondary angle closure can be caused by several underlying causes which either push the iris from the back or pull the iris forward towards the trabecular meshwork. Differentiating between the two types is of utmost importance, because treatment depends on the underlying aetiology.

To determine whether secondary angle closure is indeed different than primary angle closure, this presentation will discuss how these two types differ in terms of: definition, pathophysiology, prevalence and associated risk factors, clinical presentation, management and prognosis.



Gus Gazzard, MD

Director of Surgery, Moorfields Eye Hospital
Consultant Ophthalmic Surgeon
UCL Professor of Ophthalmology
NYU Visiting Professor (Langone Health)
Past President of UK&Ireland Glaucoma Society

The Role of LPI and Clear Lens Extraction in Primary Angle Closure Disease

Clinical decisions in the whole range of Primary Angle Closure Disease are now well supported by randomised controlled trial evidence to guide our choices. Understanding the low rate of conversion to sight-threatening disease has reduced the indications for iridotomy and recognition of the successful disease modification with lens extraction has lowered our threshold for surgery

What are the Options after Failed Trabecular MIGS and Bleb Forming Devices Procedures?

Our choices when both MIGS and bleb-surgeries have failed are more limited by greater risk of scarring induced failure. Alternative drainage routes via equatorial drainage are needed and the risks to consider (eg endothelial cell loss, tube failure) change.



Anthony Khawaja, MA(Cantab) PhD FRCOphth
Professor of Ophthalmology
UCL Institute of Ophthalmology
Honorary Consultant Ophthalmic Surgeon
Moorfields Eye Hospital NHS Foundation Trust

Primary Angle Closure Disease: Should we Even Care in Western Societies?

This lecture will describe the epidemiology of primary angle-closure disease, including geographical variation and trends over time. Specifically, the burden of the disease and risks of blindness will be discussed.

Finally, put in context with recent evidence from landmark trials, the importance of primary angle-closure in the Western world will be discussed.

Every Detail Matters: The Role of Blood Pressure and Systemic Medications in Assessing Glaucoma Risk and in the Management of the Patient with Advanced Disease

This lecture will discuss the evidence that blood pressure, its treatment, and other systemic medications have a role in the development and progression of glaucoma. Based on the evidence, potential practical recommendations of how this may influence the care of patients with advanced glaucoma will be discussed.



Gordana Sunaric Mégevand, MD, FEBOS, FMH
Medical Director, Florissant Eye Centre
- Medical Director,
Eye Research Center at Adolphe de Rothschild
Hospital in Geneva, Switzerland

Anterior segment Imaging in PACD; does it alter our clinical management?

PACD account for 26% of all glaucoma cases worldwide and yet Glaucoma resulting from angle closure induces 3x more blindness than POAG. In many parts of the world the condition is underdiagnosed and clinical management suboptimal. Timely recognition of the main mechanism, the mechanical closure of the angle, and appropriate management could to some extent prevent PACG by halting the process in the early stages.

Gonioscopy is the Gold Standard for detection and monitoring of ACD. However, many clinicians refrain from using this technique as it is subjective, needs expertise and is time-consuming.

AS-OCT provide an objective, non-contact, relatively fast and quantitative measurement that is reproducible and allows visualisation of angle structures with high resolution.

There are several reasons for disagreement between Gonioscopy and AS-OCT inherent to the two technics. Also there are several pros and cons in the use of AS-OCT: while it allows longitudinal assessment and records quantitative changes after intervention, it may over-estimate the true extent of angle closure when compared to gonioscopy with a modest positive predictive value. In addition several studies point to the fact that a relatively high number of eyes may have poor quality images thus cannot be analysed.

AS-OCT is not yet to replace Gonioscopy which remains our Gold Standard, but it can be used as an adjunctive tool to improve our diagnostic ability. Future studies will tell if Artificial intelligence with new deep learning algorithms will be capable of improving the AS-OCT performance.

Identifying subsets of patient in need for more aggressive treatment

Glaucoma is a chronic disease with a variable course of progression. Most patients under clinical care do reasonably well however some patients progress faster and are at risk for visual disability during their life time. The key goal of the clinical management is to identify those patients who would need more aggressive treatment in order to prevent functional impairment leading to significant reduction of their quality of life.

Several risk factors have been identified: the most important are high IOP, age and the stage of disease. Other risk factors, important for individual conditions, need attention when managing a progressive disease.

The decision to modify or escalate treatment relies on many different factors which should be individualized for each patient. It is not realistic to aim at halting all glaucoma progression therefore we should aim at slowing enough to preserve vision related quality of life. A better understanding of phenotypes and genotypes, an individualized approach to management and advancements in technology and AI will help us further at improving risk assessment



Stefano Miglior, MD

Professor of Ophthalmology,
University of Milan-Bicocca, Italy
UNIMIB School of Medicine and Surgery

How much vision change is clinically significant and what defines fast progressors

Any time we observe a progressive visual field deterioration in glaucoma we tend to claim the occurrence of a vision change which is related to the worsening of the disease. However, such a vision change needs to be interpreted by taking into account other features such as the absolute amount of the loss of retinal sensitivity, its topographical location, and the rate of progression. Moreover, other factors such as the stage of the disease, the presence of risk factors and life expectancy should be considered in order to better establish the clinical significance of the observed vision change. During the last ten years several studies have addressed the possibility of predicting the future rate of change in order to detect those patients that may be defined as fast progressors, and in most of these studies the criteria to identify a fast progressor is a rate of progression <1 dB/year (on the basis of a mean deviation (MD) analysis). And a catastrophic progressor is usually defined on the basis of a rate of progression <2 dB/year. Interestingly, a very practical and widespread clinical analysis such as the Trend Analysis of the Visual Field Index (VFI) has never been used to assess and define fast Progressors. The presentation will update the need of a close monitoring of the glaucoma patient, the interpretation of occurrence of vision change, the proposed strategies for an early detection of fast progressors and the possibility to implement these strategies in daily clinical practice.

Twenty years after launching the Landmark studies OHTS, EMGT and EGPS. What have we learned?

The results of the OHTS, EMGT and EGPS are the basis of solid, accurate and clinically relevant information about the management of Ocular Hypertension (OHT) and Open Angle Glaucoma (OAG). They shared the following characteristics: RCTs, long term follow up, straightforward approach i.e. treatment vs observation/placebo, OHTS and EGPS had comparable protocols and addressed the problem of OHT management in order to prevent the development of OAG. The most relevant findings of OHTS were that an appropriate IOP lowering treatment could significantly reduce the 5 years cumulative proportion of OHT individuals developing glaucoma and that a number of clinical predictive/risk factors were associated with a higher likelihood to develop glaucoma over a 5 year follow up time. Furthermore the OHTS reported the importance of HRT imaging at baseline as another risk factor for developing glaucoma. The EGPS substantially confirmed the results of the OHTS and reported the same risk profile of the OHTS in a completely different OHT population. The Collaborative OHTS-EGPS Study provided the validation of the risk calculator to estimate the individual risk to develop glaucoma over a time span of 5 years, which can be helpful in deciding in real life whether to treat or observe the OHT individuals. The EMGT addressed the problem of OAG management in order to prevent its progression. It clearly demonstrated that a 25% IOP reduction could significantly reduce by 50% the cumulative proportion of progressing OAG patients over a follow up of 5 years. PEX patients had a higher risk of progression. Several risk factors were associated with progression. EMGT reported for the first time the significant protective effect of each single mmHg of IOP reduction from baseline (explained by a 10% reduction of the risk of progression).



Thomas D Patrianakos, DO

Chair of Ophthalmology
Cook County Health

Sustained Drug Delivery Devices. Are They Getting Ready For Prime Time?

Benefits of Sustained Drug Delivery?

- Improved Adherence
- Improved QoL/Less Side Effects
- Better Efficacy

Extraocular vs Intraocular

Extraocular

- Gel Forming Drops
- Solidrop (Otero Therapeutics)
- Topical Ophthalmic Drug Delivery Device TODD (Amorphex Therapeutics)
- Bimatoprost SR Ring (Allergan)
- OTX-TP (Ocular Therapeutix)
- Contact Lenses

Intraocular

- Subconjunctival Injections
- Bimatoprost SR Intracameral Injection (Allergan)
- OTX-TIC (Ocular Therapeutix)
- iDose TR (Glaukos)
- IOL-Haptic-Based Drug Delivery (SpyGlass Pharma)

Conclusion

It's an exciting time for SDD in the management of glaucoma

Recent positive advancements have made SDD an option for many

Benefits (improved adherence/QoL/efficacy with less side effects) are real

Barriers that still need to be addressed

Loss of efficacy with time

Retention rates

Chance of infection with intraocular injections

Patient perception

Cost



Norbert Pfeiffer, MD

Univ.-Prof. Dr. med. Norbert Pfeiffer
Head of Department of Ophthalmology
Mainz University Medical Center

Management of glaucoma patients with retinal pathology

Glaucoma and retinal pathology may simply coexist and usually are difficult to handle. Retinal surgery in the presence of a filtration bleb may gravely endanger the success of filtration but can be managed. But pre-existing retinal pathology may also lead to increased IOP or even severe secondary glaucoma.

Acute IOP elevation may follow any gas endotampone, silicone oil fill, bucle surgery or any treatment causing choroidal swelling such as laser or cryo-treatment. Acute elevation may also be caused by secondary angle closure as may occur with choroidal swelling or even detachment. Postponed IOP elevation may follow the administration of topical steroids as are often necessary for a prolonged time, posterior segment haemorrhage or certainly vasoproliferative disease. Prolonged oil filling may be associated with overload and decompensation of the trabecular meshwork. Intravitreal injections have lately been identified as a source of chronic IOP elevation and need further research as to how to avoid these cumbersome complications.

When is the time for surgery and how can I convince my patients to undergo surgery?

“All glaucoma patients should undergo surgery - if there were the ideal glaucoma surgery” (Heinrich Harms, Germany). Unfortunately, there is not the ideal glaucoma surgery and, furthermore, there is hardly any part of the body that patients wish less to be operated upon than their eyes.

The right time to do surgery is if and when there is evidence that:

1. Quality of life is better with surgery than with laser or medications,
2. Progression is so fast that the patient will experience significant loss of visual function
3. Surgery is likely to solve the problem,
4. The surgeon is confident,
5. The patient is convinced that surgery is the better solution

How to achieve Nr. 5?

Whenever I see a patient who, to me, seems likely will need surgery at some stage I start by painting a glaucoma journey picture that includes as a, so far distant, option also surgery. I construct a stepladder approach which down the line after several options of medications and laser includes surgery. I take the time to establish that progression occurs, lowering IOP will solve the problem and I am confident with the surgical approach. If I am confident it usually is not a problem to convince the patient. It helps to explore all medical options including Diamox, review visual fields and OCTs and diurnal phasing to show the extent of IOP variation.

However, the patient decides whether or not to set his trust in me.



Rossetti Luca, MD

Professor and Chair,
Department of Ophthalmology, University of
Milan, and Director of the Department
of Ophthalmology and the Glaucoma Unit,
University of Milan San Paolo Hospital

**Testing in Glaucoma.
When to do More and When to do Less?**

**What do I do Differently
Compared to 10 Years ago?**



Stalmans Ingeborg, MD

Professor Doctor

Glaucoma management during pregnancy and lactation

Glaucoma management during pregnancy and lactation presents unique challenges and considerations due to the physiological changes that occur in these periods and the potential effects of glaucoma medications on the fetus and newborn. This lecture aims to provide an overview of the safest and most effective strategies for managing glaucoma in pregnant and lactating patients, focusing on the balance between maintaining maternal visual health and ensuring fetal and neonatal safety.

The safety of glaucoma medications during pregnancy and lactation is a critical concern. Many medications used to lower IOP are classified according to their potential risks to the fetus, based on animal studies and limited human data. The lecture will review the most current classifications and guidelines for the use of anti-glaucoma medications during these sensitive periods, emphasizing drugs with the lowest risk profiles and the importance of minimizing exposure without compromising glaucoma control.

Furthermore, the presentation will explore non-pharmacological options for glaucoma management, such as laser trabeculoplasty and surgery, which may be viable alternatives to medications during pregnancy and lactation.

Finally, the lecture will address the need for interdisciplinary collaboration among ophthalmologists, obstetricians, and pediatricians to ensure optimal outcomes for both the mother and the baby. Tailoring glaucoma management to the individual patient, considering the severity of the disease, the stage of pregnancy or lactation, and the specific health needs of the mother and baby, is essential for successful treatment.

Treatment in patients with advanced glaucoma

The initiation of treatment in patients with advanced glaucoma is a critical decision point that significantly influences long-term outcomes and quality of life. This lecture aims to explore the most effective initial treatment strategies for managing advanced glaucoma, emphasizing evidence-based practices and individualized patient care. Advanced glaucoma poses a substantial risk for significant visual field loss and potential blindness, necessitating an aggressive yet thoughtful approach to management.

This lecture will focus on selecting the most effective and cost-efficient initial therapies for managing advanced glaucoma. Highlighting the EGS Guidelines as well as recent evidence on this topic, the recommended practices for initiating treatment will be discussed, emphasizing the critical role of individualized care. The lecture will explore various first-line options, including pharmacological treatments, laser therapies, and surgical interventions. Each option is examined through the lens of efficacy, safety, and cost-effectiveness, providing a balanced view of how to achieve optimal intraocular pressure control while considering economic factors.



Andrew Tatham, MD

Consultant Ophthalmologist, Princess Alexandra
Eye Pavilion, Edinburgh, Scotland
NHS Scotland National Research Lead
for Ophthalmology, University of Edinburgh

Diagnostic challenges in myopic patients

Myopia is a risk factor for glaucoma, however diagnosis in myopic eyes can be challenging due to unusual optic disc appearance, pathological myopic changes, and the limitations of imaging technologies, especially normative databases.

Patients with Early Disease. Implications of Overdiagnosis in Glaucoma

Though a high proportion of people with glaucoma remain undiagnosed, especially in low resource regions, overdiagnosis is also prevalent in some settings. Overdiagnosis exposes healthy people to the risks of overtreatment and diverts resources from high risk patients with genuine disease. Potential reasons for overdiagnosis and steps to avoid it will be presented.



**Ananth Viswanathan, BSc (Hons) MBBS (Lond)
MD PhD FRCOphth**

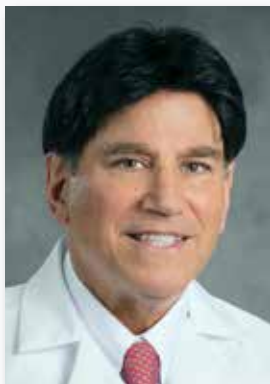
**Professor and Consultant
Moorfields Eye Hospital and UCL Institute of
Ophthalmology**

The Central Visual Field in Glaucoma. Which Testing Strategy is Most Efficient?

An accurate, efficient method of assessment for the central visual field is of paramount importance in both the diagnosis and management of glaucoma. This talk will explore the most clinically appropriate approaches to making these measurements in the various different stages of the glaucoma pathway. Learning objectives will be an improved understanding of the strengths and weaknesses of these approaches in different clinical scenarios.

How not to Miss Progression in Advanced Disease?

Advanced glaucoma presents particular problems in the detection of progression using either structural or functional measures. This talk will outline the difficulties and explore the different approaches taken to overcome them. Learning objectives will be a better understanding of the limitations of phenotyping methods in patients with advanced glaucoma and improved knowledge so as make the detection of progression as accurate and efficient as possible.



Robert N. Weinreb, MD

Chair and Distinguished Professor, Ophthalmology
Director, Shiley Eye Institute
Director, Hamilton Glaucoma Center
Morris Gleich, M.D. Chair in Glaucoma
Distinguished Professor, Bioengineering
Board Certification in Ophthalmology

Τὰ πάντα ῥεῖ καὶ οὐδὲν μένει

Despite being widely adopted, procedures performed with MIGS are not uniformly effective in sufficiently lowering intraocular pressure. However, by individualizing and targeting device placement, there is potential to enhance aqueous flow.

Determining, Predicting and Monitoring Progression

Though a high proportion of people with glaucoma remain undiagnosed, especially in low resource regions, overdiagnosis is also prevalent in some settings. Overdiagnosis exposes healthy people to the risks of overtreatment and diverts resources from high risk patients with genuine disease. Potential reasons for overdiagnosis and steps to avoid it will be presented.



ΧΟΡΗΓΟΙ ΣΥΝΕΔΡΙΟΥ

ΕΥΧΑΡΙΣΤΙΕΣ

ΜΕΓΑΛΟΙ ΧΟΡΗΓΟΙ

Το Διοικητικό Συμβούλιο της Ελληνικής Εταιρείας Γλαυκώματος ευχαριστεί θερμά όλες τις Εταιρείες που συνέβαλαν στην οργάνωση του φετινού συνεδρίου Γλαυκώματος, παρέχοντας σταθερή στήριξη στις επιστημονικές δράσεις της ΕΕΓ.



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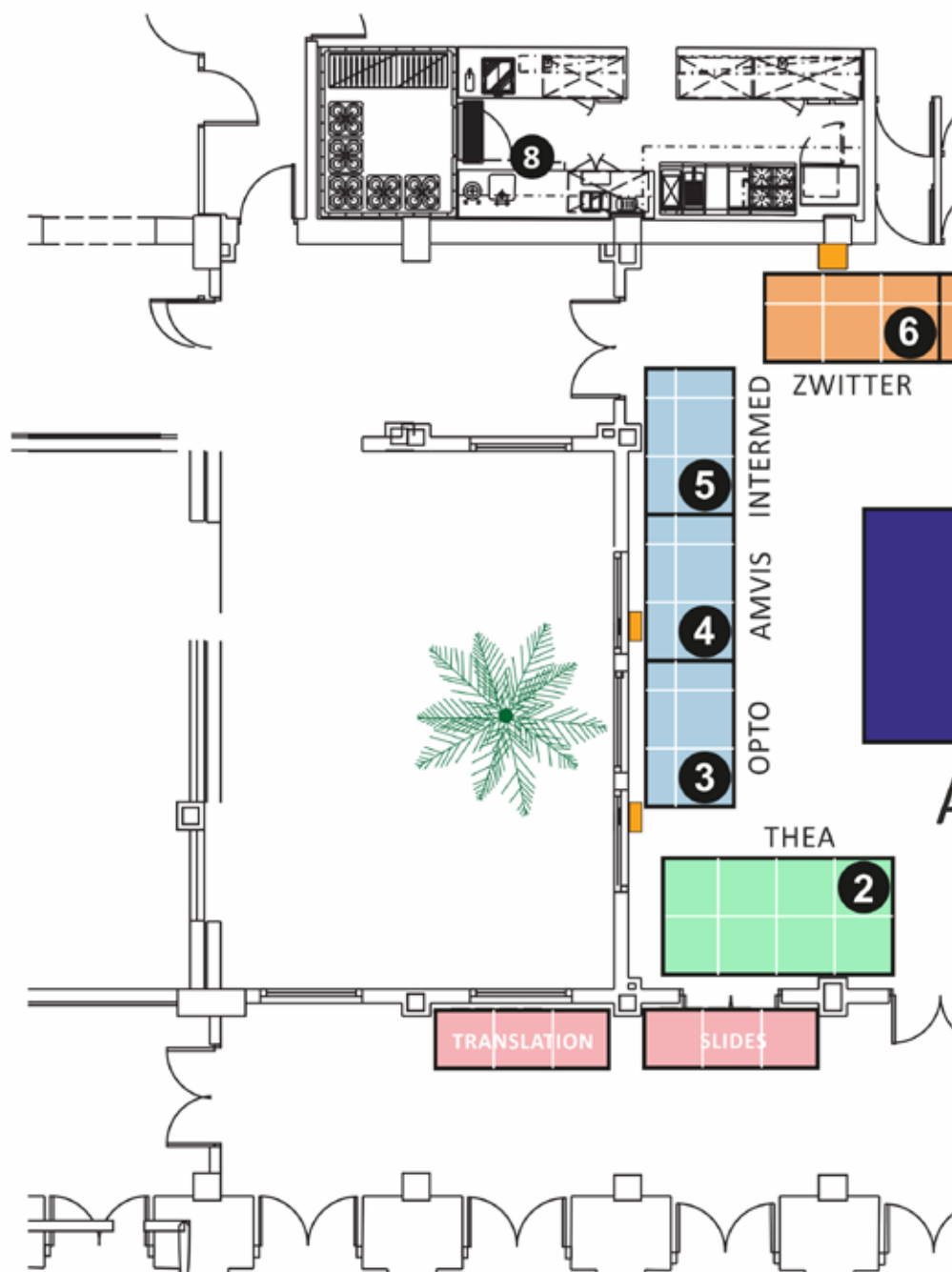
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Στέλλα Παπαδέδε