GREEK GLAUCOMA SOCIETY

29th GLAUCOMA CONGRESS

APRIL 3-5, 2025

Grande Bretagne Hotel
Athens

ΠΡΟΓΡΑΜΜΑ ΣΥΝΕΔΡΙΟΥ

Το 29ο Συνέδριο Γλαυκώματος πιστοποιείται από την Ευρωπαϊκή Εταιρεία Γλαυκώματος

29th
GLAUCOMA
CONGRESS

ΓΕΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ

ΔΙΟΙΚΗΤΙΚΟ ΣΥΜΒΟΥΛΙΟ

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 29ο Συνέδριο Γλαυκώματος θα πραγματοποιηθεί μεταξύ 3-5 Απριλίου 2025, 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 οφθαλμοσκόπιου, 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.

«ΜΕΤΑΛΛΙΟ ΤΙΜΗΣ & ΑΞΙΑΣ Α. ΑΝΑΓΝΩΣΤΑΚΗ - Α. ΤΡΑΝΤΑ»

Η Ελληνική Εταιρεία Γλαυκώματος, απονέμει κάθε χρόνο από το 1994, το «Μετάλλιο Τιμής και Αξίας Α. Αναγνωστάκη - Α. Τράντα», σε διαπρεπείς οφθαλμιάτρους, για τη συνεισφορά τους στον τομέα του γλαυκώματος.

Οι βραβευθέντες είναι (με χρονολογική σειρά):

1994 Professor Erik L. Greve, The Netherlands
1995 Professor Wolfgang Leydhecker, Germany
1996 Professor Raymond Etienne, France
1997 Professor Giuseppe Scuderi, Italy
1998 Professor Robert Ritch, USA
1999 Professor Guenter K. Krieglstein, Germany
2000 Professor George L. Spaeth, USA
2001 Professor Bruno Boles Carenini, Italy

ΒΡΑΒΕΥΘΕΝΤΕΣ ΟΜΙΛΗΤΕΣ

2002 Professor Thom Zimmerman, USA
2003 Professor Roger Hitchings, UK
2004 Professor Shlomo Melamed, Israel
2005 Professor Clive Migdal, UK
2006 Professor Paul L. Lichter, USA
2008 Professor Anders Heijl, Sweden
2009 Professor Anne Coleman, USA
2010 Professor Jeffrey Liebman, USA
2011 Professor George Baerveld, USA
2012 Professor Keith Barton, UK
2013 Professor Franz Grehn, Germany
2014 Professor Norbert Pfeiffer, Germany
2015 Professor Gabor Hollo, Hungary
2016 Professor Murat Irkec, Turkey
2017 Professor Claude F. Burgoyne, USA
2018 Professor David Garway-Heath, UK
2019 Professor Roy Wilson, USA
2022 Professor Stefano Miglior, Italy
2023 Professor Keith Martin, Australia
2024 Professor Robert Weinreb, USA

ΠΛΗΡΟΦΟΡΙΕΣ ΕΓΓΡΑΦΗΣ

ΚΑΤΗΓΟΡΙΑ	ΚΟΣΤΟΣ
ΕΙΔΙΚΟΙ ΟΦΘΑΛΜΙΑΤΡΟΙ	150 €
ΕΙΔΙΚΕΥΜΕΝΟΙ ΟΦΘΑΛΜΙΑΤΡΟΙ (μέσω εταιρειών ΣΦΕΕ)	140* €
ΙΑΤΡΟΙ ΚΑΙ ΑΛΛΟΙ ΕΥ	100 €
ΕΙΔΙΚΕΥΟΜΕΝΟΙ ΟΦΘΑΛΜΙΑΤΡΟΙ	70 €
ΝΟΣΗΛΕΥΤΕΣ, ΦΟΙΤΗΤΕΣ	ΔΩΡΕΑΝ

** Η εγγραφή δεν περιλαμβάνει επισιτιστικές υπηρεσίες συνεδρίου.*
ΚΟΣΤΟΣ ΕΠΙΣΙΤΙΣΤΙΚΩΝ: 10,00 ευρώ.

Η συμμετοχή στο Συνέδριο, 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, η συμμετοχή στο Συνέδριο είναι δωρεάν και περιλαμβάνει δυνατότητα παρακολούθησης του επιστημονικού προγράμματος, είσοδο στην έκθεση, και απλή βεβαίωση συμμετοχής. Η ιδιότητα τους θα βεβαιώνεται στη γραμματεία με την επίδειξη βεβαίωσης από τον επίσημο φορέα στον οποίο υπάγονται (π.χ. επιστολή από τον διευθυντή της κλινικής για τους νοσηλευτές, ταυτότητα επαγγελματικής κατάστασης για λοιπές κατηγορίες).
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 από τον Πανελλήνιο Ιατρικό Σύλλογο. Η παραλαβή του πιστοποιητικού προϋποθέτει την συμπλήρωση online φόρμας αξιολόγησης και την παρακολούθηση του 60% των ωρών του επιστημονικού προγράμματος, κατ' ελάχιστον.

ΑΚΥΡΩΣΕΙΣ

Το δικαίωμα συμμετοχής στο συνέδριο δεν επιστρέφεται.

ΓΡΑΜΜΑΤΕΙΑ ΣΥΝΕΔΡΙΟΥ

Έως το συνέδριο: Κατάθεση ποσού στην Εθνική Τράπεζα, σε διαταγή:
ΕΛΛΗΝΙΚΗ ΕΤΑΙΡΕΙΑ ΓΛΑΥΚΩΜΑΤΟΣ
Αριθμός Λογαριασμού 169/629649-18
IBAN No 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 διεξαγωγής του συνεδρίου, τις ακόλουθες ώρες:

ΠΕΜΠΤΗ 03/04/2025:	13.00 - 19.30
ΠΑΡΑΣΚΕΥΗ 04/04/2025:	09.00 - 19.30
ΣΑΒΒΑΤΟ 05/04/2025:	09.00 - 19.00

ΣΥΝΕΔΡΙΑΚΕΣ ΑΙΘΟΥΣΕΣ & ΧΩΡΟΣ ΕΚΘΕΣΗΣ

3 Απριλίου 2025: Το συνέδριο θα πραγματοποιηθεί, στον ημιόροφο του Ξενοδοχείου KING GEORGE.
4 Απριλίου - 5 Απριλίου 2025: 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

KING GEORGE HOTEL

14.00 - 19.00 **ΕΓΓΡΑΦΕΣ ΣΥΝΕΔΡΩΝ**

ΑΙΘΟΥΣΑ Α' - ΚΛΙΝΙΚΑ ΦΡΟΝΤΙΣΤΗΡΙΑ

14.30 - 15.30 Workshop **«Οπτικά Πεδία»**

Συντονιστές: **Π. Παπαπάνος, Δ. Γιαννούλης**

Συμμετέχοντες: ***Ρ. Χ. Μπαρτζουλιάνου***

Βασικές αρχές και στρατηγικές εξέτασης των οπτικών πεδίων

Δ. Γιαννούλης

Ερμηνεία των αποτελεσμάτων της εξέτασης των οπτικών πεδίων

Δ. Τσουκανάς

Μοτίβα γλαυκωματικής βλάβης στα οπτικά πεδία

Αχ. Μάνδαλος

Παγίδες και λάθη στην εξέταση των οπτικών πεδίων

15.30 - 16.30 Workshop **«OCT»**

Συντονίστριες: **Ε. Παπακωνσταντίνου, Π. Ντόντη**

Συμμετέχοντες: ***Ε. Δαλιεράκη***

OCT Fundamentals in Glaucoma: Bridging Structure and Function

Κ. Παπαδόπουλος

OCT Pitfalls: Artifacts, Red & Green Disease Explained

Τ. Σεπέτης

OCT in Action: Diagnosing and Monitoring Glaucoma Progression

Κ. Γιαννοπούλου

Real-World Challenges: OCT Case Studies & Key Takeaways

16.30 - 17.00 **ΔΙΑΛΕΙΜΜΑ**

17.00 - 18.00 **Κλινικά Διλήματα**

Συντονιστής: **Γ. Δαλιάνης**

Σχολιαστές: ***Α. Δαστιρίδου, Α. Βέργαδος***

Συμμετέχοντες: ***Β. Τζίμης***

Πώς παρακολουθώ το γλαύκωμα στη μυωπία

Κ. Γιαννοπούλου

Αξιολόγηση της γωνίας. Κλινική γωνιοσκοπία ή AS-OCT. Τι να επιλέξω

Ε. Γκαραγκάνη

Μπορούν οι Anti-Vegf να επηρεάσουν τον γλαυκωματικό ασθενή μας;

Α. Τριβλή

Πότε το γλαύκωμα δεν είναι γλαύκωμα

Μ. Γεωργόπουλος

Οφθαλμική υπερτονία. Πότε ξεκινάω αγωγή

18.00 - 20.00 **ΣΕ ΜΝΗΜΗ Α. ΔΙΑΓΟΥΡΤΑ**

Παρουσίαση εργασιών από ειδικευόμενους (EGS Resident Course)

Συντονιστές: **Φ. Τοπούζης, Δ. Παπακωνσταντίνου**

ΑΙΘΟΥΣΑ Β' - DRY LABs

ΕΠΙΣΤΗΜΟΝΙΚΟΣ ΥΠΕΥΘΥΝΟΣ: Δ. Παπακωνσταντίνου

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

14.00 - 14.30 **Εισαγωγή - Θεωρητικό μάθημα**

Ομιλητής: **Ι. Χαλκιαδάκης**

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, Δ. Κουρκούτας, Δ. Μπεσίνης, Β. Τζίμης

15.45 - 17.00 **ΟΜΑΔΑ 2**
Α. Δαστιρίδου, Σ. Κανδαράκης, Γ. Κοψίνης, Α. Μάνδαλος, Δ. Τσουκανάς

17.00 - 18.15 **ΟΜΑΔΑ 3**
Δ. Αλωνιστιώτης, Ε. Αναστασόπουλος, Δ. Γιαννούλης, Χ. Παππά, Θ. Φιλιππόπουλος

18.15 - 19.30 **ΟΜΑΔΑ 4**
Α. Βέργαδος, Π. Ντόντη, Ε. Παπακωνσταντίνου, Γ. Τομαής, Ι. Χαλκιαδάκης

GRANDE BRETAGNE HOTEL

09.00 - 19.00 **ΕΓΓΡΑΦΕΣ**

09.30 - 10.00 **ΕΠΙΣΗΜΗ ΕΝΑΡΞΗ**
- Χαιρετισμός Προέδρου

10.00 - 11.00 **ΣΤΡΟΓΓΥΛΟ ΤΡΑΠΕΖΙ**

Θέμα: **Οι θεραπευτικές αποφάσεις στη σύγχρονη κλινική πρακτική του γλαυκώματος**

Συντονιστές: **Ι. Χαλκιαδάκης, Χ. Τερζίδου**

Συμμετέχοντες: ***Α. Τριβλή, Π. Παπαπάνος, Ε. Αναστασόπουλος, Γ. Κοψίνης***

11.00-12.00 **ΔΙΑΛΕΞΕΙΣ**

Glaucoma Challenges in Early Diasease and / or Early in Life

Προεδρείο: Χ. Τερζίδου, Π. Παπαπάνος

Screening for Glaucoma. Where are we Today?
Anja Tuulonen

Glaucoma Suspects & Ocular Hypertensives:
Are we Wasting Resources in this Group of Individuals?
Stefano Miglior

Primary or Secondary Open Angle Glaucoma
in a Young Patient. What do I do Differently?
Anthony King

Of course I took my drops, Doctor
Francesco Goñi

12.00 - 12.15 **ΔΙΑΛΕΙΜΜΑ**

12.15 - 13.15 **ΔΙΑΛΕΞΕΙΣ**

Diagnosis and Monitoring in Glaucoma

Προεδρείο: Στ. Κανδαράκης, Γ. Κοψίνης

Home Monitoring of IOP, Diurnal Curves and Water Drinking Tests. Are There Trustworthy and/or Necessary?
Barbara Cvenkel

Clustering of Visual Field in Clinical Practice. Is it Feasible and Useful?
Ananth Viswanathan

My Best To Go Glaucoma Biomarkers in OCT.
Andrew Tatham

Imaging of the Anterior Segment. Do we still Need Gonioscopy?
Winnie Nolan

13.15 - 14.15 **ΣΤΡΟΓΓΥΛΟ ΤΡΑΠΕΖΙ**

Θέμα: **Πώς μεταφράζονται στην κλινική πράξη τα νεότερα δεδομένα από το Thessaloniki Eye Study**

Συντονιστές: **Φ. Τοπούζης, Ε. Αναστασόπουλος**

Συμμετέχοντες: ***Δ. Γιαννούλης, Ρ. Χ. Μπαρτζουλιάνου, Γ. Μπόντζος, Π. Ντόντη, Ε. Παπακωνσταντίνου***

14.15 - 15.15 **ΓΕΥΜΑ**

15.15 - 16.15 **ΔΟΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ** **(σελ. 26)**

16.15 - 17.15 **ΔΙΑΛΕΞΕΙΣ**

Glaucoma Meets Other Subspecialties

Προεδρείο: Ε. Αναστασόπουλος, Ι. Χαλκιαδάκης

Evaluation and Management of Glaucoma in Patients with Corneal Diseases
Carlo Traverso

Glaucoma isn't the Only Optic Neuropathy. How do I Avoid Getting in Trouble?
Esther M. Hoffmann

Premium IOLs in Glaucoma Patients: Yes or No?
Julián Garcia Feijóo

Master Protocol for Evaluating Real-World Data.
Anja Tuulonen

17.15 - 17.30 **ΔΙΑΛΕΙΜΜΑ**

17.30 - 18.30 **ΔΙΑΛΕΞΕΙΣ**

Glaucoma Challenges in Late Disease and/or Late in Life

Προεδρείο: Γ. Μαγκουρίτσας, Αν. Κώνστας

How do I Approach the Pelevant Co-Morbidities in this Age Group?
Stefano Miglior

Does Advanced Age Affect the Surgical Procedure of Choice?
Hari Jayaram

The Patient is in Late Disease but Early in Life. What do I do Differently?
Anthony King

When Enough is Enough? Accepting the Inevitable.
Fransesco Goñi

18.30 - 19.30 **ΣΤΡΟΓΓΥΛΟ ΤΡΑΠΕΖΙ**

Θέμα: **Υποσχόμενες διαγνωστικές και θεραπευτικές προσεγγίσεις στο γλαύκωμα στον 21ο αιώνα**

Συντονιστές: **Α. Κώνστας, Β. Κοζομπόλης**

Συμμετέχοντες: ***Α. Κατσάνος, Δ. Μικρόπουλος, Ε. Παναγιώτου, Θ. Φιλιππόπουλος***

GRANDE BRETAGNE HOTEL

09.30 - 10.30 **ΣΤΡΟΓΓΥΛΟ ΤΡΑΠΕΖΙ**

Θέμα: **Ποιους άλλους παράγοντες εκτός από την ενδοφθάλμια πίεση πρέπει να συζητήσω με τους ασθενείς μου. Μια ολιστική προσέγγιση για το γλαυκωματικό ασθενή**

Συντονιστές: **Α. Κατσάνος, Δ. Μικρόπουλος**

Συμμετέχοντες: ***Α. Βέργαδος, Α. Δαστιρίδου, Κ. Καραμπάτσας, Γ. Μπόντζος***

10.30 - 11.30 **ΔΙΑΛΕΞΕΙΣ**

New Ideas in Glaucoma Management

Προεδρείο: Ε. Καρμίρης, Θ. Φιλιππόπουλος

AI in Glaucoma Clinical Applications & Challenges.
Ananth Viswanathan

New Horizons in Glaucoma Medical Therapy.
Barbara Cvenkel

Non-IOP Related Glaucoma Management.
Luca Rossetti

Minimal Clinical Important Differences in Glaucoma Trials.
Giovani Montesano

11.30 - 12.00 **ΔΟΡΥΦΟΡΙΚΗ ΔΙΑΛΕΞΗ** (σελ. 26)

12.00 - 12.15 **ΔΙΑΛΕΙΜΜΑ**

12.15 - 13.15 **ΔΟΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ** (σελ. 26)

13.15 - 14.45 **ΔΙΑΛΕΞΕΙΣ**

Evidence Based Medicine: How do (Should) Landmark Trials Affect Our Practice?

Προεδρείο: Φ. Τοπούζης, Δ. Παπακωνσταντίνου

How do we Evaluate the Results of a Trial.
Common Sources of Bias.
Giovani Montesano

In Ocular Hypertension and Early Open Angle Glaucoma.
Luca Rossetti

In Advanced Open Angle Glaucoma.
Hari Jayaram

In Angle Closure Glaucoma.
Winnie Nolan

«ANAGNOSTAKIS -TRANTAS» Award
Honorary Lecture:
To MIGS, or not to MIGS, that is the Question!
Gordana Sunaric-Mégevand

14.45 - 15.45 **ΓΕΥΜΑ**

15.45 - 17.00 **ΔΙΑΛΕΞΕΙΣ**

Surgery for Glaucoma

Προεδρείο: Β. Κοζομπόλης, Α. Κατσάνος

Advances in Laser Treatment for Glaucoma.
Esther M. Hoffmann

Does Everybody with well Controlled Early Glaucoma Need a Trabecular MIGS Procedure at the time of Cataract Surgery?
Andrew Tatham

Positioning of Bleb Forming Devices in the Treatment Algorithm.
Julián Garcia Feijóo

Who is the Ideal Patient for Filtration Surgery?
G. Sunaric-Mégevand

What are the Treatment Options after a Failed Trab or a Failed Tube?
Carlo Traverso

17.00 - 18.15 **ΣΤΡΟΓΓΥΛΟ ΤΡΑΠΕΖΙ**

Θέμα: **Προβληματισμοί στην καθημερινή αντιμετώπιση του γλαυκώματος. Παρουσίαση περιστατικών.**

Συντονιστές: **Δ. Παπακωνσταντίνου, Γ. Μαγκουρίτσας**

Συμμετέχοντες: ***Γ. Δαλιάνης, Σ. Κανδαράκης, Ε. Καρμίρης***

18.15 - 18.30 **ΕΡΩΤΗΣΕΙΣ - ΣΥΖΗΤΗΣΗ**

18.30 - 19.00 **ΤΕΛΕΤΗ ΒΡΑΒΕΥΣΗΣ ΔΙΑΓΩΝΙΣΜΟΥ «ΣΕ ΜΝΗΜΗ Α. ΔΙΑΓΟΥΡΤΑ»**

19.00 **ΛΗΞΗ ΣΥΝΕΔΡΙΟΥ**

ΕΤΑΙΡΙΚΕΣ ΕΚΔΗΛΩΣΕΙΣ

ΠΑΡΑΣΚΕΥΗ 4 ΑΠΡΙΛΙΟΥ 2025

15.15 - 16.15 **ΔΟΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ**

Θέμα: **Νέα Θεραπευτικές Προσεγγίσεις**

Συντονιστής: **Α. Γ. Κώνστας**

Συμμετέχοντες: ***Δ. Μικρόπουλος, Γ. Κυμιωνής, Α. Κατσάνος, Β. Κοζομπόλης***

ΣΑΒΒΑΤΟ 5 ΑΠΡΙΛΙΟΥ 2025

11.30 - 12.00 **ΔΟΡΥΦΟΡΙΚΗ ΔΙΑΛΕΞΗ**

Θέμα: **Ολιστική φαρμακευτική φροντίδα στο Γλαύκωμα**

Ομιλητής: **Φ. Τοπούζης**

12.15 - 13.15 **ΔΟΡΥΦΟΡΙΚΟ ΣΥΜΠΟΣΙΟ**

Θέμα: **Βελτιώνοντας την αποτελεσματικότητα και μειώνοντας τα προβλήματα στη φαρμακευτική θεραπεία του γλαυκώματος. Ο Μινώταυρος, ο Λαβύρινθος και ο Μίτος της Αριάδνης**

Συντονιστής: **Φ. Τοπούζης**

Συμμετέχοντες: ***Ε. Αναστασόπουλος, Σ. Κανδαράκης, Ε. Καρμίρης***

ΠΕΡΙΛΗΨΕΙΣ ΔΙΑΛΕΞΕΩΝ

B. Cvenkel

MD, PhD, Head of Glaucoma Dept, Clinic for Ophthlamic Diseases, University Medical Centre Ljubljana, Slovenia

New Horizons in Glaucoma Medical Therapy

Recent advances in glaucoma treatment have focussed on improving efficacy, reducing side effects and providing more convenient treatment options. Several new approaches and emerging therapies for the treatment of glaucoma show promise, particularly in the areas of novel drugs, delivery systems and neuroprotection strategies.

Rho-kinase inhibitors, a new class of drugs, consist of 3 agents (ripasudil, netarsudil and fasudil) that are available in some countries. They lower intraocular pressure by reducing the resistance to the outflow of aqueous humour from the Schlemm's canal by relaxing the trabecular meshwork. In addition, the Rho-kinase inhibitors reduce the synthesis of reactive oxygen species in the trabecular meshwork cells, which contributes to the death of these cells. Netarsudil 0.002% ophthalmic solution is the only Rho-kinase inhibitor approved in Europe with similar efficacy to timolol but a higher rate of ocular side effects. There are several Rho-kinase inhibitors currently under investigation. Nitric oxide donors are another class of agents that not only lower IOP but may also increase blood flow and anti-inflammatory activity. The only preparation available (not in Europe) is Latanoprostene Bunod, which releases latanoprost and a NO-donating molecule, butanediol mononitrate. A nitric oxide-donating bimatoprost is currently in phase III development. The

development of novel prostaglandin receptor agonists that lower IOP by stimulating EP2 and EP3 receptors in addition to FP appears promising. Omidenepag isopropyl 0.002%, a prostanoid EP2 receptor agonist, lowers IOP by increasing trabecular and uveoscleral outflow and has comparable efficacy to latanoprost. The novel fixed combinations, of which netarsudil/latanoprost is available in some European countries, have shown high efficacy due to their effect on episcleral venous pressure. Fixed combinations in the pipeline include Rho-kinase inhibitors (ripasudil) with brimonidine and sepetaprost (an FP/EP3 receptor agonist). Adenosine receptor modulators are another group currently under investigation. Their effect on IOP depends on binding to the receptor subtype. Trabodenoson is a selective A 1 receptor agonist that increases aqueous humour outflow via the matrix metalloproteinase-2 signalling pathway and has the potential for a neuroprotective effect. The side effects of topical treatment and treatment adherence are an important issue in glaucoma treatment. Novel approaches focus on increasing drug absorption from the ocular surface through the use of mucoadhesive polymers, slow-release implants and nanoformulations, none of which are available for clinical use. The enhancement of drug delivery by injection of sustained-release bimatoprost has only been approved by the FDA for a single application for safety reasons. Studies on the intracameral and intraocular use of latanoprost, travoprost and ciliary neurotrophic factor are ongoing.

Home monitoring of IOP, Diurnal Curves and Water Drinking Tests. Are they Trustworthy and/or Necessary?

Intraocular pressure (IOP) remains the only modifiable factor in the development and progression of glaucoma. Although it is important to measure IOP at diagnosis and after IOP-lowering treatment, the evaluation of IOP-lowering therapy is usually based on a few IOP measurements during the consultation time. Studies have shown that IOP fluctuates throughout the day and over longer periods

of time and that a single measurement of IOP in the office may not be representative of most of the day. There is no consensus on which IOP parameter (mean IOP, peak IOP, IOP fluctuation) is the most important risk factor for glaucoma progression. The lack of IOP data is an important limiting factor in glaucoma management. Twenty-four hour IOP monitoring can provide the most accurate measurements, but is hospital dependent, inconvenient and costly. A daytime curve may be an option, but it is questionable whether the pattern of IOP remains similar over subsequent days or over longer periods of time. Collecting more IOP readings at home has led to the development of self-tonometers and continuous pressure measurement devices. The iCare HOME tonometer has been shown to be accepted by the majority of patients and is easy to use. It allows the measurement of IOP in the usual position (i.e. supine position during the night). Home monitoring of IOP may be suitable for motivated patients who appreciate being actively involved in their treatment. The water-drinking test, which tests the eye's outflow facility after drinking 800-1000 ml in a short time, could be an alternative to diurnal IOP monitoring, as a strong positive correlation between peak IOP values from the water-drinking test and diurnal IOP monitoring has been found in glaucoma patients. In some patients, visual field loss progresses with apparently controlled IOP at office visits. In these selected patients, obtaining further IOP data may be helpful to modify and/or adjust treatment to prevent progression.

J. Garcia Feijóo

Chairman of the Department of Ophthalmology of the San Carlos Clinical Hospital and Professor of Ophthalmology at Complutense University of Madrid

Positioning of Bleb Forming Devices in the Treatment Algorithm

Bleb forming devices, Less Invasive Glaucoma Surgery or Minimally Penetrating glaucoma surgery are positioned as a less invasive surgical option for patients with moderate to advanced open-angle glaucoma who have insufficient intraocular pressure (IOP) control despite maximally tolerated medical therapy or previous laser procedures. Some years ago these surgeries where considered as an intermediate step between traditional filtering surgeries, such as trabeculectomy, and less invasive interventions like SLT or MIGS. Its design allows for a controlled and sustained reduction in IOP, with a lower risk of complications compared to conventional filtering surgery. However the indications have evolved and now, in my opinion, are gaining acceptance as a viable alternative to trabeculectomy, especially in cases where long-term IOP reduction is needed but the patient or surgeon wishes to avoid the higher risk profile of traditional surgery. It is particularly considered for patients who may not be ideal candidates for trabeculectomy due to comorbidities, previous surgeries, or patient preference. Moreover they can be used as an alternative to glaucoma drainage devices after failed conventional filtering procedures. However, long-term data and comparative studies are still evolving to fully establish its place in glaucoma management guidelines

Premium IOLS in patients with glaucoma. Yes or No

We will discuss the different Premium IOLs and the potencial indications in patients with glaucoma. There are no contraindications for monofocal Toric IOLs or monofocal Plus IOLs other than the possibility of IOL decentration and tilt. However, the use of Multifocal IOLs (MIOLs) in patients with glaucoma and even ocular hypertension (OHT) requires careful consideration due to potential effects on contrast sensitivity and overall visual quality. For multifocal IOL Moderate and Advanced glaucoma are very well stablished contraindications. In my opinion even patients with early glaucoma are not good candidates for MIOLs as contrast sensitivity could be affected even in early stages with minor VF defects. Moreover OHT patients could progress unexpectedly and rapidly so even in this case, patients have to be informed and should understand the potential risks and benefits, especially if their life expectancy is long. In PSX glaucoma or even PSX syndrome MIOLs should not be used due to the long term IOLs stability complications.

F. Goñi

Dr, Head of the Ophthalmology Dept and Consultant of the Glaucoma Unit of the Mollet Hospital, Barcelona, Spain

Of course I took my drops, doctor

When asked directly and in a straightforward manner, the patient will answer yes, I'm using the drops. Treatment adherence is difficult to assess. This presentation reviews key concepts to better identify possible barriers for treatment nonadherence and strategies for recognizing and improving it.

When Enough is Enough? Accepting the Inevitable

In our clinical practice, it is not uncommon to face terminal situations related to glaucoma as a disease, to the patient as a suffering human being, and to the doctor as the leader of therapeutic decisions. This presentation reviews shortly the defining characteristics of each of the parties in this three-way relationship, leading to a situation that ultimately results in a difficult decision such as "enough is enough".

E. Hoffmann

Consultant Ophthalmologist,
Head of Glaucoma Diagnostic Center,
Universitatsmedizin der Johannes Gutenburg - Universitat Mainz

Advances in laser treatment for glaucoma

The presentation includes new recommendations for first line treatment for glaucoma and an objective view on the future treatment for glaucoma

Glaucoma isn't the only optic neuropathy. How do I avoid getting into trouble?

The talk will present differential diagnoses of glaucoma including various non-glaucomatous optic neuropathies. Identification comparison to glaucoma optic neuropathy will be discussed.

H. Jayaram

Ass. Professor UCL Institute of Ophthalmogy, Consultant Ophthalmic Surgeon, Director of Glaucoma Service, Moorfields Eye Hospital, NHS Foundation, London

Does Advanced Age Affect the Surgical Procedure of Choice?

The prevalence of glaucoma continues to increase with an ageing population and consequently we frequently have to address the challenging of progressing glaucoma in an ageing population. This talk will address the challenges of performing glaucoma surgery in an older population, whilst balancing the benefits of surgical intervention against the risk associated with surgery in this vulnerable group of patients, their willingness to undergo ocular surgery.

EBM - How do (should) Landmark Trials Affect Our Practice In Advanced Open Angle Glaucoma?

The management of Advanced Open Angle Glaucoma has been a clinical challenge with prior evidence based upon clinical practice derived from a prior era. This talk will discuss the available contemporary evidence that can influence the clinical decision making of glaucoma specialists caring for this challenging cohort of patients.

A. King

**MB, BCh, MD, MMedSci, FRCOphth,
University of Nottingham, Notts,
Division of Ophthalmology
and Visual Sciences**

Primary or secondary open angle glaucoma in a young patient - what do I do differently

The treatment approach for open angle glaucoma may vary according to the underlying aetiology of the condition and the age of the patient. While the treatment options remain the same for all open angle glaucoma patients the order in which these options are undertaken may vary and age may influence the treatment pathway adopted. We will explore the options that exist and important considerations in deciding treatment and evidence that exists to support treatment choices.

The patient is in late disease but early in life. What do I do differently

The treatment approach for glaucoma may vary according to the severity of disease and the age of the patient. Patients presenting early in life with advanced disease have longer to become severely visually impaired during their lifetime and this may influence the treatment pathway adopted. We will explore the options that exist and important considerations in deciding treatment and evidence that exists to support treatment choices.

S. Miglior

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

Glaucoma suspects and ocular hypertensives. Are we wasting resources in this group of individuals...?

Individuals with Ocular Hypertension (OHT) are about the 4% of the general population above the age of 40. Glaucoma Suspects (individuals with a suspicious optic disc and a normal or borderline visual field and a normal IOP) should be added to the group of OHT, thus increasing the number of functionally normal individuals with a higher risk to develop POAG over time and/or already affected by a very early stage of the disease.

They have a potentially high impact on the amount of resources (economical, human and logistic) that should be allocated in order to provide the correct diagnosis and to organize the proper follow up and clinical management. Today we have adequate indications for an Evidence Based (EB) management of OHT, which may simplify the whole process and considerably limit the waste of resources in this area. We do not have yet EB indications for the best management of glaucoma suspects, but a proper knowledge of basic ophthalmological signs, and a correct interpretation of Imaging and Visual Field test results may help in simplifying the overall diagnostic and management processes.

It is not possible to foresee the impact of a correct clinical practice on the possible

saving of economical, human and logistic resources. On the other hand, however, it has to be kept in mind that during the last decades a very strong and continuously repeated message concerning "early diagnosis of glaucoma" has been spread out all over general ophthalmologists and general population. The result is that today potential patients tend to be extremely anxious for a potentially blinding disease and ophthalmologists tend to over-diagnose and over-treat.
The presentation will try to highlight these concepts and to update present findings to better elucidate the whole context.

How do I approach the relevant co-morbidities in this (late disease/late in life) age group...?

The management of glaucoma in the elderly, when glaucoma may be advanced or even end-stage, needs a very challenging clinical approach, which should take into account a number of significant variables: stage of the disease, binocular functional status, life expectancy (which does not simply depend on the crude age, but also on the presence/absence of systemic co-morbidities, the psychological status of the patient, the assessment of IOP and of the local and systemic impact of topical therapy, and, whenever possible, the assessment of visual field rate of progression. Among these, co-morbidities represent a significant problem, either if they are ocular or if they are systemic.
If they are ocular (age-related macular degeneration, retinal vascular diseases, ocular inflammation, advanced cataract, severe corneal diseases...) the ophthalmologist should be aware of the functional impact of the ocular co-morbidities on the proper assessment of the glaucomatous eye. At the same time the ophthalmologist should be well aware that a proper management of glaucoma must be titrated in order to treat the disease and limit the impact of whatever glaucoma treatment on the ocular co-morbidities.
If they are systemic, the ophthalmologist should consider the possibility of under-treating, in case of significant diseases that may significantly shorten life

expectancy of the patient. In other situations, such as neuro-degenerative diseases, which affect the accurate diagnosis and follow up of glaucoma, the ophthalmologist should consider to try to simplify the medical treatment or to decide for surgery. In case of systemic vascular diseases the approach to glaucoma surgery should be accurately planned in order to reduce the risk of interference of systemic medications on the surgery itself and during the first period of post-op follow up. The presentation will try to highlight these concepts and to update present findings to better elucidate the whole context.

G. Montesano

Azienda Ospedaliera San Paolo,
Polo Universitario,
AO San Paolo

How do we evaluate the results of a trial. Common sources of bias

Evaluating the results of a clinical trial requires a critical understanding of potential biases that can influence outcomes. This presentation will introduce common strategies to minimize bias, focusing on the gold standard: randomized, placebo-controlled, double-masked clinical trials. It will then systematically explore how bias can arise when deviations from this protocol occur. Recognizing that the gold-standard approach is not always feasible - such as in surgical trials - alternative measures to mitigate bias in these cases will also be discussed. The presentation will also explore how the choice of outcome can change the interpretation of the results, specifically focusing on the difference between intraocular pressure control and disease progression control.

Minimal Clinical Important Differences in Glaucoma Trials

In glaucoma trials, defining meaningful treatment effects is essential for both clinical decision-making and patient care. This presentation will focus on the concept of Minimal Clinically Important Differences, emphasizing disease progression as a key outcome measure, primarily assessed through visual field monitoring. While intraocular pressure (IOP) reduction remains the main modifiable risk factor in glaucoma management, its correlation with long-term visual field preservation is imperfect. We will explore the relationship between visual field loss and vision-related quality of life, highlighting why disease progression - rather than IOP alone - should be the primary measure of treatment efficacy. The limitations of IOP-based outcomes and the need for clinically relevant, patient-centred measures will also be discussed.

W. Nolan

Consultant Ophthalmologist,
Glaucoma Service,
Moorfields Eye Hospital
NHS Foundation Trust

Imaging of the anterior segment: Do we still need gonioscopy?

Over the last decade the use of anterior segment imaging has become a more established part of the diagnostic work up for glaucoma patients. Where it used to be an adjunct to gonioscopy in helping confirm the presence and mechanisms of angle closure, it now is used more routinely for excluding angle closure in 'virtual clinic' settings or as a replacement for gonioscopy. However, gonioscopy is still an important examination technique which requires skill and practice. In this talk there will be discussion of the role of imaging and the advantages and disadvantages of the two types of angle examination techniques.

How should landmark trials affect our practice in angle closure?

The ZAP and EAGLE studies are the two key trials which have changed practice in the management of patients with narrow angles and primary angle closure disease. The ZAP study showed a small benefit of prophylactic laser iridotomy for narrow angles and this talk will discuss how in the UK we now suggest limiting this intervention to patients thought to be at higher risk of acute angle closure. The EAGLE trial showed that clear lens extraction achieves better control of IOP in patients with PAC and PACG compared with iridotomy. This talk will discuss the exclusion criteria for EAGLE and the importance of counselling patients on CLE and identifying those who may be at higher risk of complications following surgery. This will be illustrated with case example(s).

G. Sunaric Mégevand

Medical Director,
Florissant Eye Centre - Medical Director,
Eye Research Center at Adolphe de Rothschild Hospital in Geneva

To MIGS or not to MIGS, this is the question

Glaucoma is still the leading cause of irreversible blindness and glaucoma surgery remains a crucial means to halt the progression of the disease when medical therapy has failed. In recent years we have witnessed a shift in glaucoma surgical practice patterns. While Trabeculectomy has historically been preferred, providing significant and sustainable IOP reduction for medically uncontrolled or progressive disease, we witness today an increased use of MIGS mainly guided by their safety and ease of use. The originally claimed indications are no longer respected and MIGS are used for various types and stages of glaucoma despite their known limited efficacy. The evidence on which the use of MIGS is based, the incentives what this means for the global health care is discussed.

Who is the ideal patient for filtration surgery

Since its description, over 50 years ago, Trabeculectomy has remained the Gold Standard in the surgical management of uncontrolled and progressive glaucoma but concerns about bleb-related complications have contributed to an expanded use of tube shunts and of newer, safer surgeries. However most comparison of these alternative surgeries have confirmed the superiority of Trabeculectomy in reducing IOP but at the expense of potential post-operative complications. When planning surgery, It is important to evaluate the risk- benefit in the given patient, to adopt an individualized approach balancing potential complication with long term efficacy.

A. Tatham

Consultant Ophthalmologist, MD, MBA, FRCSEd, FRCOphth, FEBO, PGDip Cataract and Refractive Surgery,
Princess Alexandra Eye Pavillion, Edinburgh

My best to go glaucoma biomarkers in OCT

Optical coherence tomography (OCT) has transformed glaucoma diagnosis by providing objective, high-resolution imaging of key structural biomarkers. The most important OCT parameters include retinal nerve fibre layer (RNFL) thickness, retinal ganglion cell layer (GCL) and Bruch's membrane opening-minimum rim width (BMO-MRW), all of which help detect glaucomatous damage at an early stage. However, several challenges persist, particularly regarding the reliability of normative databases, the presence of artifacts, and difficulties in high myopia.

Beyond diagnosis, OCT plays an important role in monitoring glaucoma progression by detecting structural changes over time. However, challenges such as the "floor effect" - where RNFL and GCL measurements become too thin to detect further progression - can limit its utility in advanced disease. Additionally, measurement variability, scan quality issues, and the need to account for normal age-related change remain important considerations. Despite these limitations, OCT remains an indispensable tool, complementing functional tests.

Does everybody with well controlled early glaucoma need a trabecular MIGS procedure at the time of cataract surgery?

Minimally invasive glaucoma surgery (MIGS), particularly trabecular bypass procedures, has become an attractive option for patients undergoing cataract surgery who have coexisting glaucoma. These procedures offer a favourable safety profile and can reduce medications and provide additional intraocular pressure reduction. However, whether or not all patients with mild to moderate glaucoma should be offered a trabecular MIGS procedure at the time of cataract surgery remains controversial. Not all patients require additional pressure lowering and cataract surgery alone has been shown to lower IOP. Overtreatment may also expose patients to unnecessary risks and the patient and healthcare system to unnecessary costs. While MIGS may be beneficial for many, a tailored approach is necessary and patient-specific factors, such as target IOP, disease progression and medication burden should guide decision-making.

C. Traverso

MD, Professor and Chairman, Clinical Oculistica of Di.N.O.G.M.I., University of Genova, IRCCS Azienda Ospedaliera Univeristaria San Martino

What are the Treatment Options after a Failed Trab or a Failed Tube?

When trabeculectomy or implanting a tube drainage device fails to control intraocular pressure (IOP), various surgical options can be considered.

One is repeat or additional trabeculectomy, in case there is still viable conjunctiva in the superior quadrants. On may modify the technique by using different surgical strategies to optimize filtering success.

Another alternative is the placement of long-tube drainage devices (GDDs), either after failed trabeculectomy or as a second implant. Cyclodestruction is also an option to reduce the production of aqueous humor in the eye. This approach can be particularly useful for patients who may not be candidates for further incisional surgery or for those seeking a less invasive approach.

Overall, the choice of subsequent surgical intervention depends on factors like the cause of failure, the patient's overall health, prior surgeries, and individual anatomy. A thorough preoperative assessment and a collaborative approach involving the patient in decision-making are essential.

Evaluation of patients with glaucoma and concomitant corneal disease

Managing patients with glaucoma who also have corneal diseases presents unique challenges, particularly in ensuring accurate intraocular pressure (IOP) measurements, addressing potential complications from surgical interventions and the effects of topical medications on corneal health.

A. Tuulonen

Professor
Tampere Univerity Hospital
Tays Eye Centre
Tampere, Finland

Master Protocol for Evaluating Real-World Data

Based upon available literature, all systems suffer from the same challenges: huge variability of care practices (despite guidelines), simultaneous under- and over-care as well as unsustainable increase of costs. The Western world has already demonstrated that simply doing more what we currently do, i.e., more eye care and more spending cannot guarantee better access to care, nor to better quality, outcomes, or satisfaction with care.

Due to multi-fold variabilities within national and international ophthalmic subspecialities, it is obvious that all cannot be right. As nothing is intrinsically cost-effective, it is important to understand and measure the impact of the current work being done and benchmark our patient outcomes to other organizations.

The US National Institute of Health defines Master Protocol as a trial design that can test multiple subpopulations in parallel under a single protocol, without the need to develop new protocols for every trial. The metrics need to be 1) meaningful both for patients and clinicians, 2) easily and systematically recordable and available from structured electronic health records, and 3) understandable to aid decision making at different levels of health care. In addition, it is crucial to confirm that we measure, report and compare the same aspects of care using the same metrics and methods. These steps offer platforms for adapting trial designs

using real-world data for multiple purposes. They require collaboration of clinicians with deep practice experience and questioning minds working closely together.
The digital platform of the Master Protocol is planned to work as a searchlight for scanning the similarly structured RWD data sets between clinics in peer-to-peer benchmarking. Both detected differences and similarities in data sets and outcomes may be valuable and guide to deeper understanding of care practices, including their impacts on outcomes.

Screening for Glaucoma: Where Are We Today?

The benefits of screening should out-weigh any harms (such as under- and over-care, false positive, negative and uncertain findings) and be cost-effective. Systems outcome matter also in screening, not just test performance which ignores the steps that follow after the test. It is these steps that actually determine how much benefit and harms screening would bring.
For example, evaluation of fundus pictures by artificial intelligence (AI) is time-efficient compared to human evaluation. However, obviously AI, neither e.g., genetic testing, cannot guarantee high enough attendance to screening which has reported to be just above 10% even when screening for targeted high-risk glaucoma populations. In addition, when also Western health care systems are already suffocating with the current patient overflows, it does not seem justified to refer even more patients for their follow-up. However, even when the evidence does not support systematic screening (as is currently the case in glaucoma), screening may be interpreted justified as 'at least we are doing something'.
A long list of questions still remains to be answered related to high-risk case finding/screening in order to balance between over and under referral and care, how to set a 'good enough' referral threshold, how to define test intervals, how to utilize and optimize the already existing systems, and how to deal with social-economic-cultural barriers preventing implementation.

ΒΡΑΒΕΙΟ
Α. ΑΝΑΓΝΩΣΤΑΚΗ
Α. ΤΡΑΝΤΑ
2025

Gordana Sunaric Mégevand

Gordana Sunaric Mégevand is a glaucoma specialist in Geneva, Switzerland. Her career started at the University Hospital Geneva, followed by a 3 years fellowship in glaucoma and anterior segment surgery in Capetown, South Africa. At return she headed the Glaucoma unit at the University Hospital in Geneva, then founded in 2013 the Centre Ophtalmologique de Florissant (COF) and the Clinical Research Centre Foundation A de Rothschild. She served as president of the EBO (European Board of Ophthalmology), and was awarded the Peter Eustace medal in 2020 for contribution towards upgrading education in ophthalmology in Europe. She was an Exco - member of the EGS (European Glaucoma Society) and has actively contributed in the elaboration and realisations of the EGS - FEBOS Glaucoma exam and the EGS Glaucoma Fellowship.

ΕΥΧΑΡΙΣΤΙΕΣ

ΜΕΓΑΛΟΙ ΧΟΡΗΓΟΙ

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

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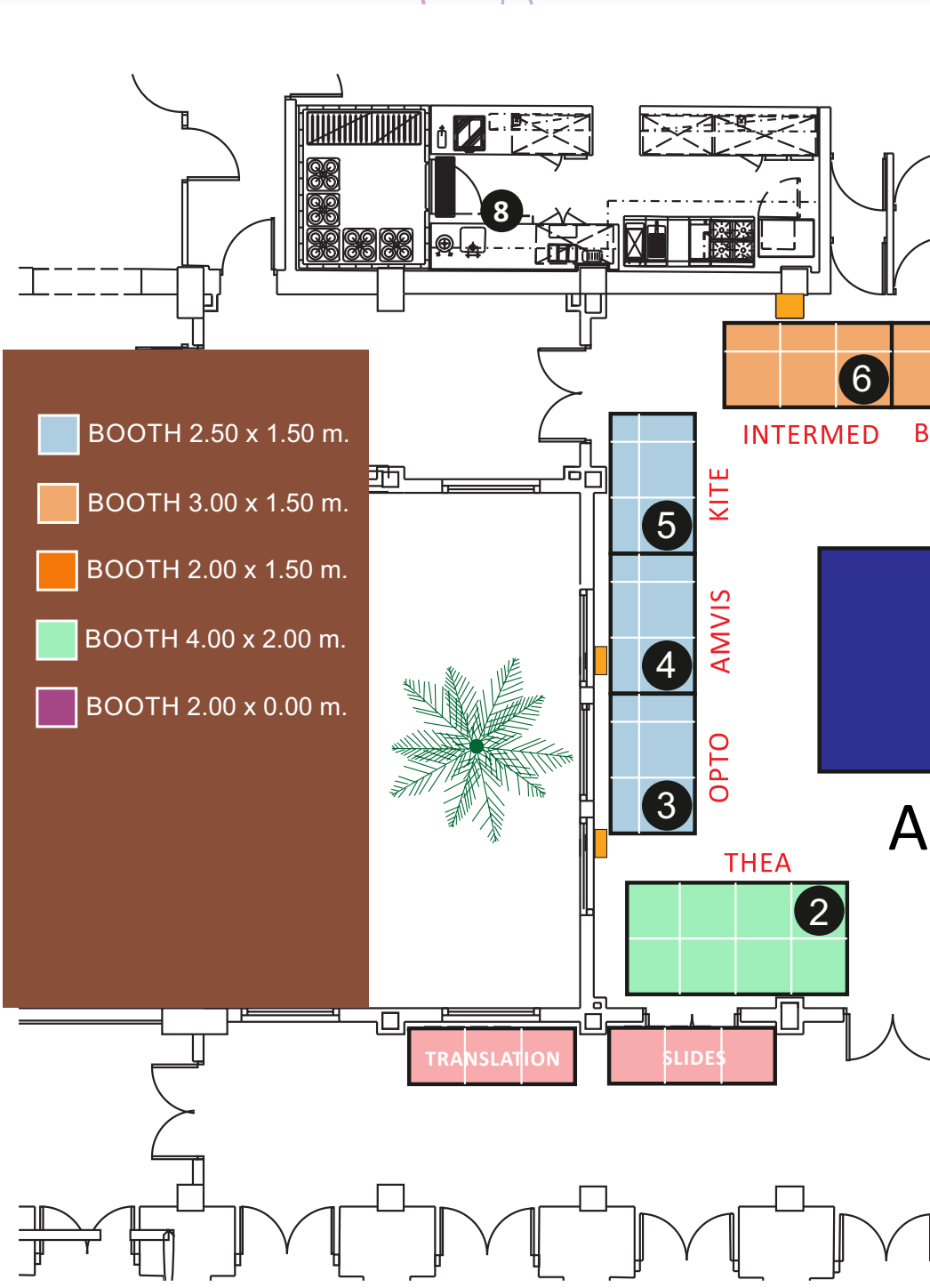
ΚΑΤΟΨΗ ΕΚΘΕΣΗΣ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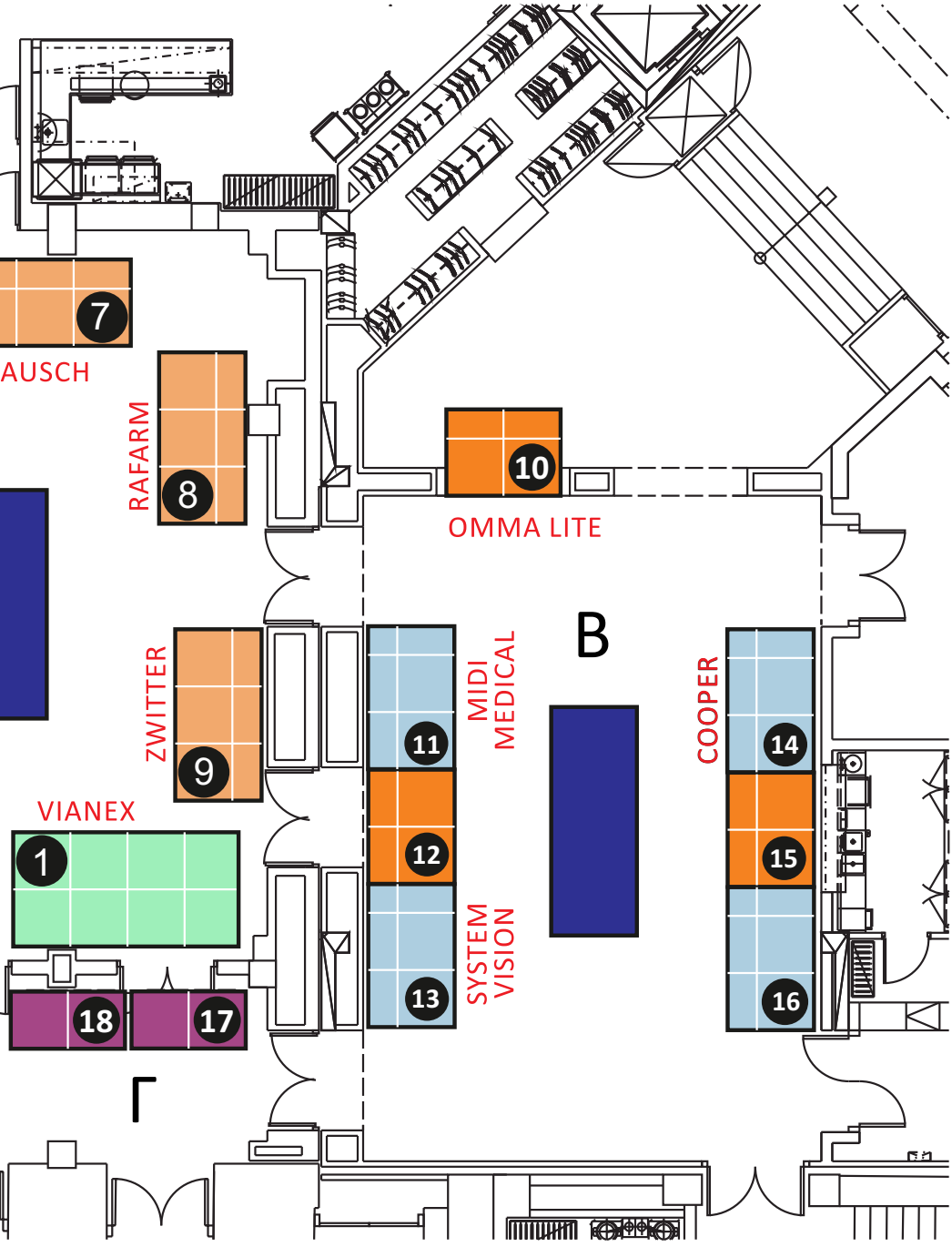
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ΣΗΜΕΙΩΣΕΙΣ

29th
GLAUCOMA
CONGRESS

ΕΛΛΗΝΙΚΗ ΕΤΑΙΡΕΙΑ ΓΛΑΥΚΩΜΑΤΟΣ

29th GLAUCOMA CONGRESS

ΕΠΙΜΕΛΕΙΑ ΟΡΓΑΝΩΣΗΣ ΣΥΝΕΔΡΙΟΥ & ΕΙΚΑΣΤΙΚΩΝ
Σ. ΠΑΠΑΔΕΔΕ