EDITORIAL

Current Glaucoma Practice: The Covid-19 Impact

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It is our choices, Harry, that show what we truly are, far more than our abilities. (*J. K. Rowling, Harry Potter and the Chamber of Secrets, 1998*)

History does not repeat itself, but it sure does rhyme. Like Covid-19 today, the H1N1 Spanish flu pandemic (1918–1919) caught the world unawares. By the time decision makers paid attention, the fate of those most vulnerable was sealed. The result was 50 million deaths due to influenza.[1]

A hundred years hence, we are somewhat better prepared: we know what causes Covid-19, there is a definite discourse around its treatment and the possibility of a vaccine, and social distancing is a part of our lexicon. Yet, as the death toll rises each day, we struggle to cope, personally and professionally.

We are specialists, and this is from far afield. Yet, our patients look to us for guidance and comfort. As their doctors and caregivers, our patients want answers amidst heightened insecurity, even as guidelines and recommendations—often specific to geography, population, and disease—are evolving each day.

Closer home, the Covid-19 overhang is much more real and present for us than just unrealistic expectations of certitude. Even in normal times, we took care of people, often asymptomatic, often progressing, often scared, often under threat of blindness, and often not compliant with therapy. Add now, a new worry about our clinic inadvertently becoming a center for Covid-19 transmission, and the consequent impact on our staff, our patients, and ourselves.[2,3]

And finally, zooming right in to what we do: we will now ponder over our choice of tonometers: disinfection woes vs reliability, aerosolization concerns vs cost of disposable tips. We could defer visual fields until disinfection protocols are formulated, we could accept optical coherence tomography (OCT)-only algorithms of glaucoma diagnosis, but only if we are ready to shut away the structure vs function paradigm we have believed in.[4]

Will we treat more ocular hypertensives in the absence of visual fields, or less? Will the red-green disease be the new glaucoma pandemic? Will we do less surgeries or more, if we choose the less invasive surgeries over conventional incisional surgeries? Will minimally invasive glaucoma surgery (MIGS) and tubes finally come of age, replacing trabeculectomies?

But glaucoma practitioners are no strangers to ambiguity: we have harped on the art of glaucoma for long. The numbers were there to aid us: in mm Hg, decibels, and microns. Suddenly, there will be fewer absolutes to fall back upon, fewer progression analyses, fewer slopes and triangulations. There will be filters that fail, intraocular pressures (IOPs) that decompensate, and visual fields, if and when we can do them, that deteriorate. There will be decisions to be taken, a strange new triage, and definitely more novel data points in the clinical paradigm than ever before.[5]

In all this, there will be questions with correct answers, those without any answers at all, and there will also be questions we will fail to ask: clinical and ethical. We will see colleagues falter and we will see our own mistakes come back to haunt us 6 weeks or 6 months or 6 years from now.

That's just the science. New line items in variable costs and fewer patients absorbing rising fixed costs will mean higher cost of glaucoma care. Disposable equipment, PPE, staggered staff timings, fewer patients in the clinic, fewer procedures, fewer surgeries, waste management: the list is long.[6]

So how do we navigate this? First, know that you are not alone. We will, all of us, stumble, sometimes we will hesitate, and sometimes we will look for the unsaid that guides many a glaucoma consult. And that there will be times when we will need to see our patients and not just their eyes or eye pressures.[7] There will be other times when a hug, or a longer handshake, is the only answer. It is then that we will need to draw on reserves of strength that exists within us, unseen or otherwise. We all well know that the cure of the disease is actually worse than the disease itself. And that's why so much of what we do in glaucoma is nonverbal communication; it is a relationship born of absolute trust.

Our patients will need to see our faces—and not only through acrylic slit lamp shields, or through face masks, or on computer screens. There will be times when we will need to see them smile, and when we will need them to see our smiles—for successes will be ours too. And there will be a time when we will.

Our calling has always been to preserve the quality of life in a bad disease. The premium on this purpose is even higher today. Long after we are gone, history will judge us not by our science, but by the kindness with which we protected those who needed us most.

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