SCIENTIFIC PROGRAM

MEETING CO-CHAIRS:

Eric Fry, MD
Tina Tran, MD
Lisa McKay, CRNA
MEETING PURPOSE, TARGET AUDIENCE & OBJECTIVES
The purpose of the OAS annual scientific meeting is to educate OAS members, as well as other interested healthcare professionals, and share information that will enable them to provide the highest level of anesthesia service during ophthalmic surgery. This meeting is of interest to anesthesiologists, ophthalmologists, certified registered nurse anesthetists, registered nurses and other ophthalmic medical professionals.

At the conclusion of the conference, attendees will be able to:
1. Identify the latest anesthesia techniques for ophthalmic surgery.
2. Review pertinent historical and anatomical information related to ophthalmic surgery.
3. Evaluate different anesthesia techniques to determine which might warrant a change in current practice.
4. Generate an increased or sustained interest in developing knowledge, acquiring skills and continuing education in the area of ophthalmic anesthesia.

ACCREDITATION INFORMATION
Physicians
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the University of Alabama School of Medicine (UASOM) and the Ophthalmic Anesthesia Society. The UASOM is accredited by the ACCME to provide continuing medical education for physicians.

The University of Alabama School of Medicine designates this live activity for a maximum of 14.25 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The University of Alabama School of Medicine is an equal opportunity/affirmative action institution.

Certified Registered Nurse Anesthetists (CRNAs)
This program has been prior approved by the American Association of Nurse Anesthetists for 13.00 Class A CE credits; Code Number 1035060; Expiration Date 9/24/2017.

FACULTY DISCLOSURE
In accordance with the Standards for Commercial Support issued by the Accreditation Council for Continuing Medical Education (ACCME), the University of Alabama School of Medicine requires resolution of all faculty conflicts of interest to ensure CME activities are free of commercial bias.

The following faculty members have indicated that they do not have anything to disclose that, in the context of their presentations, could be perceived as a potential conflict of interest:

Gary Cass
Zhuang Fang
Gregory Fox
Eric Fry
Randolf Harvey
Robert Langston
David Markoff

Lisa McKay
Paul Munden
Scott Olitsky
Richard Rivers
Tina Roberts
David Stange
Tina Tran

The following faculty members have disclosed a financial interest/arrangement or affiliation with a commercial company who has provided products or services relating to their presentations or commercial support for this continuing medical education activity. All conflicts of interest have been resolved in accordance with the ACCME Updated Standards for Commercial Support.

Athir Morad – Thomas and Dorothy Tung Endowment (grants/research support); University of Chicago Neurology Grand Rounds (payment for lectures)

Lindsey Nelson – CTSS (honorarium); Infusystems (honorarium); ETT Stylet (patent)

Derek Sakata – Dynaesthetics (stock/shareholder; patents; royalties)

Jochen Steppan – Johns Hopkins University Department of ACCM (employment); Arginase II: A Target Treatment of Aging Heart and Heart Failure. US 2009/0298912A1, awarded 12/2009 (patent); Hines: Stoelting’s Anesthesia and Co-Existing Disease, 7e (royalties)

William Wiley – Imprimis (grants/research support; consulting fees; stock/shareholder; honorarium; support for travel to meetings; Board membership; employment; payment for development of educational presentations; patents; royalties; payment for lectures)

GRANT ACKNOWLEDGEMENT
The University of Alabama School of Medicine and the Ophthalmic Anesthesia Society acknowledge educational grants for the support of this activity from Halozyme and Edge Pharmacy Services
FRIDAY, SEPTEMBER 22

9:00 am - 5:00 pm  
6th Floor Pre-function  
Registration Open

1:00 - 5:00 pm  
Gallery Ballroom,  
6th Floor  
General Session

Moderator: Eric Fry, MD, Fry Eye Associates, P.A., OAS President

1:00 - 1:05 pm  
Welcome & Opening Remarks  
Eric Fry, MD

1:05 - 1:45 pm  
Pediatric Ophthalmology & Adult Strabismus Surgery  
Scott Olitsky, MD, Children’s Mercy Kansas City  
Describe the basic types of surgery performed by pediatric ophthalmologists and adult strabismus surgeons, and when certain types of procedures may be used; Identify when different types of anesthesia techniques may be used in pediatric ophthalmology and adult strabismus surgery.

1:45 - 2:35 pm  
Respiratory Depression and Consideration for Monitoring Following Ophthalmic Surgery  
Athir Morad, MD, Johns Hopkins Medicine  
Discuss the impact of “MAC” sedation and General Anesthesia on post-operative respiration; Review the efficacy of post-operative monitoring in capturing respiratory depression.

2:35 - 3:15 pm  
Anesthetic Considerations in Glaucoma Surgery  
Paul Munden, MD, Oklahoma City VA Hospital  
Discuss the considerations for comfort and pain control unique to glaucoma surgery; Implement improved coordination between anesthetist and surgeon to enhance outcomes for glaucoma surgeries.

3:15 - 3:40 pm  
Gallery Ballroom Foyer  
Coffee Break

3:40 - 4:20 pm  
Tips and Tricks: Time-Saving Techniques  
Tina Roberts, RN, Precision Lens  
Identify techniques to improve patient flow and efficiency for staff; Identify two areas to improve infection control in their facilities and save time.
FRIDAY, SEPTEMBER 22 (cont.)

4:25 - 4:45 pm
Poster Preview
Poster Presenters
Hear previews of the posters that will be featured at the evening reception!

4:45 - 5:00 pm
Q & A and Discussion for Previous Lectures
Attendees’ chance to ask questions and further discuss content from previous lectures.

5:00 - 7:00 pm
6th Floor Pre-function
Exhibitor & Poster Reception
Use the drink ticket in your name badge for a complimentary beverage during the reception.

P1: Higher Dose of Palonosetron Versus Lower Dose of Palonosetron Plus Droperidol for Preventing PONV After Eye Enucleation and Orbital Hydroxyapatite Implant Surgery: A Randomized, Double-Blind Trial
Fang Tan, Eye Ear, Nose and Throat Hospital of Fudan University, Shanghai, China

P2: Overview of Ophthalmic General Anesthesia: A Year’s Experience
Abhisesh Shrestha, MD, Tilganga Institute of Ophthalmology, Kathmandu, Nepal

P3: Anesthetic Management of a Pre-Term with Pulmonary Hypoplasia for Vitreo-Retinal Surgery
Shobha Ravishank, MBBS, DA, Medical Research Foundation, Chennai, India

P4: A Rare Case of Intra-Operative Seizures
Sujatha Vittal, MBBS, DA, Medical Research Foundation, Chennai, India

P6: Amniotic Membrane Transplantation in Patients with Corneal Perforation due to Anesthetic Abuse Keratopathy Case Report
Anna Hovakimyan, MD, PhD, S. Malayan Eye Center, Yerevan, Armenia

P7: The Effects of Thermal Softening of Laryngeal Mask Airway on Post-Operative Pharyngolaryngeal Adverse Events in Pediatric Patients Undergoing Strabismus Surgery
Shuang Shuang Li, MA, Hospital of Fudan University, Shanghai, China

P8: Two Case Reports of Incidental Diagnosis of Amyloidosis After Removal of Protective Eye Tape Used for Surgery
Asca Zavala, MD, MPH, MD Anderson Cancer Center, Houston, Texas

Full text abstracts may be found on pages 7-9.
SATURDAY, SEPTEMBER 23

7:30 am - 12:00 pm
Registration Open

6th Floor Pre-function

8:00 - 8:30 am
Continental Breakfast

8:00 - 8:30 am
Gallery Ballroom Foyer

8:30 am - 12:00 pm
General Session
Moderator: Tina Tran, MD, Johns Hopkins Hospital, OAS President-Elect

8:30 am - 12:00 pm
Gallery Ballroom, 6th Floor

12:00 - 1:30 pm
Lunch Break (Attendees on own)

1:30 - 3:30 pm
General Session
Gallery Ballroom, 6th Floor
Moderator: Tina Tran, MD, Johns Hopkins Hospital

1:30 - 2:10 pm
Ask the Society
Tina Tran, MD, Johns Hopkins Hospital
The OAS President-Elect will review questions and topics posted to the scientific advisory panel and will lead a discussion and debate about the questions with members of the audience.

2:10 - 2:50 pm
Pro/Con Debate: Anesthesia Provides Both Sedation and Ophthalmic Block?
Dave Stange, CRNA, Medical and Surgical Eye Associates (pro) & Athir Morad, MD, Johns Hopkins Medicine (con)
Describe the benefits of Propofol in an ophthalmic block model; Discuss the benefits of the block model for the surgeon; Review the risks and complications of the ophthalmic block; Discuss alternatives to the performance of ophthalmic blocks by anesthesiologists.

2:50 - 3:30 pm
The Peri/Retrobulbar Block: Utilizing the Geometrical Approach - A Shifting Paradigm
Randolf Harvey, CRNA, Florida Eye Clinic & Ambulatory Surgery Center
Direct the needle tip parallel to the orbital apex, the optic nerve and the macula; Identify the orbital-globe relationship utilizing an external measurement and the geometrical approach.

8:30 - 9:10 am
Cardiac Disease and Implications of Ophthalmic Surgery
Jochen Steppan, MD, Johns Hopkins Medicine
Identify patients presenting for ophthalmological surgery who are at increased perioperative risk due to severe cardiovascular disease; Discuss perioperative management strategies for patients with severe cardiovascular disease presenting for ophthalmological surgery.

9:10 - 9:50 am
Update on Hemorrhagic Occlusive Retinal Vasculitis (HORN)
Gregory Fox, MD, Retina Associates, P.A.
Identify the syndrome HORN; Discuss the potential risks and benefits surrounding the use of antibiotics during intraocular surgery.

9:50 - 10:30 am
Eye Injury Associated with Surgery and Anesthesia
Zhuang Fang, MD, University of California, Los Angeles
Discuss the incidence and common causes of eye injury during non-ophthalmic surgery; Discuss the treatment and strategy of prevention for eye injury during non-ophthalmic surgery.

10:30 - 11:00 am
Coffee Break

11:00 - 11:45 am
Hustead Memorial Lecture: Use of MKO Melt in Ophthalmic Surgery
William Wiley, MD, Cleveland Eye Clinic
Discuss the options of using sublingual sedation; Discuss the dosing recommendations, medication strategies, timing, and risks and benefits of sublingual sedation.

11:45 am - 12:00 pm
Q & A and Discussion of Previous Lectures
Attendees’ chance to ask questions and further discuss content from previous lectures.
**SUNDAY, SEPTEMBER 24**

7:30 - 8:00 am  
**Gallery Ballroom Foyer**  
Continental Breakfast

8:00 - 8:30 am  
**Gallery Ballroom**  
6th Floor

**Member Business Meeting**  
Open to all OAS members: Join us for breakfast and your chance to hear updates from leadership on OAS’ finances, membership and future initiatives. Also, participate in the election of the 2018 Board of Directors.

8:30 am - 12:00 pm  
**Gallery Ballroom**  

**General Session**

Moderator: Lisa McKay, CRNA, OAS Secretary

8:30 - 9:00 am  
**Smart Oxygen Delivery System**

Derek Sakata, MD, University of Utah & Robert Langston, CRNA, John Moran Eye Hospital

Describe oxygen delivery systems for non-intubated patients undergoing sedation; Describe respiratory monitoring of non-intubated patients undergoing sedation.

9:00 - 9:30 am  
**Cataract Surgery: From Less Drops to Drop-less**

David Markoff, MD, Mountain Eye Associates

Describe the different methods of administering antibiotic and anti-inflammatory medications for cataract surgery; Discuss the pros and cons associated with transitioning from drops to drop-less cataract surgery.

9:30 - 10:00 am  
**Non-Narcotic Perioperative Analgesia: A New Optic for the Ophthalmic Anesthesiologist**

Lindsey Nelson, MD, Vail Valley Medical Center

Discuss the causes of the current opioid epidemic and the implications for the perioperative management of pain in patients undergoing eye surgery; Discuss the pathways of pain and current effective non-narcotic strategies in both the acute pain and chronic pain patient.

10:00 - 10:20 am  
**Gallery Ballroom Foyer**  
Coffee Break

10:20 - 10:50 am  
**Propofol 'Sedation': Is it Mad, Bad and Dangerous to Know?**

Michael Phelps, MD, Johns Hopkins University

Describe the continuum of consciousness that includes MAC and general anesthesia; Identify potential concerns using general anesthesia without a secure airway.

10:50 - 11:30 am  
**You be the Judge: Interesting Cases**

Howard Palte, MD, Bascom Palmer Eye Institute

Describe clinical situations in which anesthetic management is contentious; Outline key considerations in opting between MAC and GA; List patient factors that may preclude surgery in an outpatient facility; Discuss important equipment and backup facilities for day-case eye surgery; Debate the pros and cons of preoperative assessment for eye surgery cases; Recognize common clinical syndromes associated with ocular pathology.

11:30 am - 12:00 pm  
**Cataract Surgery: The Good, the Bad and the Ugly!**

Eric Fry, MD, Fry Eye Associates, P.A.

Discuss the appropriate steps to take when faced with a choroidal hemorrhage; Determine when topical or retrobulbar anesthesia for cataract surgery is appropriate in standard and complex cataract surgery; Discuss strategies for lens placement in an eye with compromised or absent capsular support.

12:00 pm  
Adjourn
**ABSTRACTS**

Abstracts will be presented in a Poster Reception on Friday evening in the Gallery Ballroom Foyer.

**P1: Higher Dose of Palonosetron Versus Lower Dose of Palonosetron Plus Droperidol for Preventing PONV After Eye Enucleation and Orbital Hydroxyapatite Implant Surgery: A Randomized, Double-Blind Trial**

Fang Tan, Eye Ear, Nose and Throat Hospital of Fudan University, Shanghai, China

**Purpose:** Postoperative nausea and vomiting (PONV) is commonly observed after eye enucleation and orbital hydroxyapatite implant surgery. This prospective, randomized, double-blind trial was conducted to investigate the hypothesis that compared with monotherapy of lower dose of palonosetron, adding droperidol could further improve the incidence of PONV and achieve similar prophylaxis of PONV after the aforementioned surgery as higher dose of palonosetron.

**Methods:** 129 patients (ASA-II), aged between 18 and 70 years, scheduled for eye enucleation and orbital hydroxyapatite implant surgery were enrolled in this study. They were randomized into three groups: Group P2.5 (2.5 μg/kg palonosetron), Group P7.5 (7.5 μg/kg palonosetron), and Group P+D (2.5 μg/kg palonosetron and 15 μg/kg droperidol). Patients received different antiemetic regimens 5 minutes intravenously before surgery. Severity of nausea and vomiting, complete response (CR) rate during postoperative 72h period was assessed.

**Results:** All patients completed the research. The nausea score of Group P2.5 was statistically higher than those of the other two groups in 0-4 and 24-48 h (P<0.05). Vomiting scores among all groups were similar during all intervals (P>0.05). Compared with Group P2.5, the CR rate was prominently improved at all intervals except 4-72h in Group P+D, and was also elevated at 24-72h in Group P7.5 (P<0.05). Less patients in Group P2.5 didn’t experience any nausea or vomiting throughout the study (49%), compared with those in Group P7.5 (67%) and Group P+D (81%) (P<0.01).

**Conclusions:** Combining a low-dose palonosetron with droperidol potentiated the efficacy of prophylaxis of PONV and achieved similar prophylaxis effect with higher dose of palonosetron.

**P2: Overview of Ophthalmic General Anesthesia: A Year’s Experience**

Abhisesh Shrestha, MD, Tilganga Institute of Ophthalmology, Kathmandu, Nepal

**Background:** This study sought to describe and analyze different ophthalmic cases undergoing in general anesthesia in TIO. **Method:** Retrospective review of all the data for patient undergoing general anesthesia in our center (2016).

**Results:** Total number of cases done in this 1389 cases were done in which Male were 854(61.4%) and Female were 535(38.6%). The smallest patient was preterm baby (36+ gestational Age) and oldest patient being 84 years. In accordance to different specialty maximum cases were done by oculoplastics unit (34%) followed by pediatric unit (30%). Complication were 1.4% without any mortality.

**Conclusion:** Ophthalmic surgery is a day care and low risk surgery, but the anesthesia technique is same as for all other surgeries. Most of the procedures are under loco-regional anesthesia, the group requiring general anesthesia are mostly pediatric population, which always carries high risk for anesthesia. Hence careful assessment and vigilance is required in ophthalmic anesthesia for better patient outcome.

**P3: Anesthetic Management of a Pre-Term with Pulmonary Hypoplasia for Vitreo-Retinal Surgery**

Shobha Ravishankar, MBBS, DA, Medical Research Foundation, Chennai, India

Anesthetic management of a pre-term with pulmonary hypoplasia. Pulmonary hypoplasia is a spectrum of malformations characterized by incomplete development of lung tissue. It is a condition characterized by a reduction in the number of lung cells, airways and alveoli that results in lower organ size and weight. Pulmonary hypoplasia can be either unilateral or bilateral. With this background, a case of pre-term with an hypoplastic lung for a retinal surgery is discussed.

**P4. A Rare Case of Intra-Operative Seizures**

Sujatha Vittal, MBBS, DA, Medical Research Foundation, Chennai, India

Perioperative seizures pose a difficult and challenging situation for the anesthesiologist. Management of seizures in epileptic and non-epileptic patients in the perioperative period calls for efficient team work. This is a case report about a middle-aged lady who came for vitreo retinal surgery to our institute 5 days after anemia correction. Intra and post operatively she developed generalized tonic clonic convulsions. A diagnosis of Posterior Reversible Encephalopathy syndrome (PRES) was made and management is discussed.

**P6. Amniotic Membrane Transplantation in Patients with Corneal Perforation due to Anesthetic Abuse Keratopathy**

Anna Hovakimyan, MD, PhD, S. Malayn Eye Center, Yerevan, Armenia

Anesthetic abuse keratopathy is a rare, frequently unrecognized clinical problem caused by topical ocular medications.
Topical anesthetics have repeatedly been shown to be toxic if used for prolonged periods and their cytotoxic results are dose-dependent. Toxic reactions of the ocular surface can take different forms. The toxic effect includes frank epithelial loss, stromal edema, infiltration and corneal opacification. A diffuse punctate epitheliopathy, occasionally in a whorl pattern, can be observed in more severe cases. The most severe cases may involve a corneal epithelial defect of the inferior or central cornea, stromal opacification and neovascularization. This type of epithelial disease can be seen in damage of limbal stem cells. We are presenting 2 cases of anesthetic abuse associated with corneal perforation. Report of Cases: A 45 y/o male was referred to Cornea Uveitis Department complaining of tearing, light sensitivity, blepharospasm, foreign-body sensation and blurred vision. The complaints were present for a week. Past ocular history was remarkable for doing welding without protective glasses which resulted in corneal erosion. Patient was very sensible and used topical anesthetic (Tetracaine 1%) frequently (every one hour). On slit lamp examination, the patient had OU central corneal ulcer with epithelial defect and stromal infiltration, granuloma looking lesions in a/ch with large feeding vessel from the limbus inferiorly. The patient was told to stop topical anesthetic immediately and was prescribed topical antibiotics for prophylactics, Doxycycline bid, cycloplegic agent and artificial tears. Patient also received Bethametasone sub/tenon injection. On the next visit patient presented with corneal perforation due to continued frequent usage of topical anesthetic. So, he underwent amniotic membrane transplantation. On the next day after surgery the anterior chamber was recovered. The amniotic membrane got resolved on the 10th after surgery. The defect of corneal epithelium reduced twice in size. The patient was advised to continue the same regimen of treatment. Two weeks later patient was seen again with improvement. The epithelium was almost healed, the stromal infiltrate was resolved on 50%. The patient was seen again after 2 weeks with great improvement, the epithelium was totally healed and corneal anterior stromal scar was formed. The patient was advised to continue artificial tears 4 times a day and never use anesthetic eye drops. The second patient was 22 y/o female presented with corneal epithelial defect, stromal melt paracentrally and limbal injection in the left eye. Past ocular history was remarkable for mild trauma resulting in erosion. On examination, she claimed using topical Tetracaine 1% every 2 hours. She was told to stop topical tetracaine and start tears, oral Doxycycline 100mg bid, topical chloramphenicol 0.25% qid, cycloplegics. Despite the prescribed treatment she presented with corneal perforation. The patient underwent amniotic membrane transplantation and continued the medical treatment. One month later the eye got quiet, the epithelium was totally healed, mild stromal scar was formed. Conclusion: Thus, amniotic membrane transplantation is an effective method of treatment for corneal perforation, especially due to anesthetic abuse keratopathy complicated by stromal melting.

P7. The Effects of Thermal Softening of Laryngeal Mask Airway on Post-Operative Pharyngolaryngeal Adverse Events in Pediatric Patients Undergoing Strabismus Surgery
Shuang Shuang Li, MA, Hospital of Fudan University, Shanghai, China

Background: Postoperative pharyngolaryngeal adverse events are commonly reported following airway manipulation. It has been reported that thermal softening of tracheal tubes reduces the incidence of sore throat and vocal cord injuries. We hypothesized that thermal softening of LMA may be effective for decreasing pharyngolaryngeal complications. The current study was primarily designed to investigate whether thermal softening of LMA reduced postoperative sore throat, hoarseness or blood stain on LMA. Methods: We randomized 104 pediatric patients aged 3-12 years who underwent elective strabismus surgery into two groups depending on whether the LMA was warmed or not before insertion. The LMAs were placed in thermostat[40˚] in the thermal softening group (n=51) or in room temperature in the control group (n=53) for 30 min. Anesthesia was induced with propofol, fentanyl and cisatracurium, and maintained with sevoflurane in air-oxygen. The LMAs were inserted and the intracuff pressure was adjusted to 40 mmHg. The primary outcomes were the incidence of sore throat, hoarseness and blood stain on LMA. Results: Baseline demographic data were comparable between groups. Sore throat occurred less frequently in the thermal softening group than in the control group (5/53 vs 0/51, p=0.073). However, the incidence of hoarseness (2/53 vs 0/51, p=0.492) and blood stain on LMA (1/53 vs 1/51, p=0.492) were comparable between the two groups. Conclusions: Laryngeal mask airway softened by warming decreased the postoperative incidence of sore throat. Therefore, thermal softening of LMA before insertion seems to be helpful in reducing pharyngolaryngeal adverse events.

P8. Two Case Reports of Incidental Diagnosis of Amyloidosis After Removal of Protective Eye Tape Used for Surgery
Asca Zavala, MD, MPH, MD Anderson Cancer Center, Houston, Texas

Introduction: Amyloidosis is a disease resulting from abnormal protein deposits and can manifest locally or systemically (1). Diagnosis is confirmed with biopsy and histological exam of the affected organ. We present two...
cases of patients who were incidentally diagnosed with amyloidosis after the removal of the tape used for ocular protection during anesthesia resulted in bilateral eyelid skin detachment. Case Reports: Case 1. A 53-year-old man with multiple myeloma presented for femur intramedullary nailing. After anesthetic skin induction, clear tape (3M Transpore™) was placed over the patient’s eyelids for ocular protection. When removed at the end of the procedure, the tape caused upper eyelid in detachment, resulting in bilateral cutaneous abrasions (Figure 1A). An ophthalmology consult revealed abnormal eyelid pigmentation, so the skin specimen was sent for dermatopathology workup. Recommended therapy for the abrasions was bacitracin ophthalmic ointment QID. A positive Congo red stain of the tissue was consistent with the diagnosis of amyloidosis (Figure 2). The abrasions improved with one week of ointment application. Case 2. A 63-year-old man with multiple myeloma presented for total thyroidectomy. Upon awakening from anesthesia, the patient had significant ecchymosis over both right and left eyelids. Patient stated he has a history of bruising and bleeding easily ever since his diagnosis of multiple myeloma and primary amyloidosis of light chain type. Discussion. Overall, the incidence of skin injury caused by medical adhesive tape is 15.5% (2). Cutaneous manifestations of systemic amyloidosis occur in 30-40% of patients (3), therefore it is important to recognize the potential harm of adhesive use in this patient population. Amyloid angiopathy results when amyloid is deposited in blood vessels, resulting in friable capillaries that can rupture with minimal trauma such as rubbing of the eyelids, sneezing, or coughing. Recommendations for ocular protection particularly for patients with known amyloidosis include ocular lubrication and covering the eyelids with gauze before taping (4). Avoiding deep Trendelenburg position, Valsalva maneuvers, and eye manipulation can also help minimize the risk of trauma (3). It is also important to ask the patient if they have any history of eyelid bruising during the anesthetic patient interview to prevent this complication from occurring.
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