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## THE ENLIGHTENED OFFICE

### Patient compliance: Taking ownership

At AAO meeting and OIS, the topic of adherence was conspicuous by its absence, and presence.

BY CYNTHIA MATOSSIAN, MD

If you attended the Ophthalmic Innovation Summit (OIS) in November, you must have noticed the number of entrepreneurs who shared a vital endpoint concerning the purpose of their products: they addressed compliance and adherence.

Whether they were still involved in proof of concept or completing phase 2 enrollment, the entrepreneurs behind these proposed therapies all used a shared lexicon, such as "sustained released," "reducing current burden" and "noninvasive."

This isn't to suggest that larger pharmaceutical companies don't know there is a problem. As keynoter Brent Saunders said at OIS, most glaucoma patients do not take their medications.

#### MOVING ON UP

In this space last month, we talked about why our patients are not adherent; this month, we will talk about the health care field's responsibility in this matter.

It became apparent to me, after attending last month's AAO Conference that compliance is moving from a B-list topic to an A-list issue. In the huge hall holding the myriad scientific posters, compliance was still a B-list issue. Perhaps a few had the word "compliance" or "adherence" in their titles.

But in the day-long OIS gathering, dealing with adherence was the common enemy. The weapons? Sustained release injections for retinal diseases; punctal plugs designed to deliver, via the tear film, a variety of therapies; nanoparticles and microparticles intended for sustained delivery of medication; and for wet age-related macular degeneration, interference with vessel formation and leakage reduction. It's almost as if they all read Don Budenz' November 2009 paper in *Ophthalmology*:

"The body of literature on adherence interventions in chronic diseases ... shows that although many interventions have been tested and evaluated, only some are successful. Paradigms derived from behavioral medicine and nursing offer valuable lessons on how to motivate patients to change behavior, but these activities require skill sets not traditionally taught in medical school. Just as there are myriad causes of nonadherence, the interventions most likely will need to be multifaceted and tailored to the individual patient."

#### TAKING OWNERSHIP

Instead of trying to change the patient, these entrepreneurs are changing the therapies. They are, at least from my vantage point, taking ownership of the adherence problem.



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In our practice, we use therapies that, if not consciously designed with compliance in mind, are the next best thing. But they are not cheap. And that fact forces the patient to make a decision: do I pay more for a daily branded NSAID or the four-times-a-day ketorolac? And you know what happens — the patient remembers to take it twice a day at best. We use, when warranted, intracameral therapies during surgery. These help the patient — but they often cost us.

This is a penny-wise, pound-foolish system, as people may be progressing with their disease processes needlessly. Let us hope we make huge strides in new delivery systems to circumvent patient compliance. **OM**



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