# When Irish Eyes Are Smiling

Sean Strub avoids CMV retinitis and gets vision-improving surgery

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Laboraory blood analyses and other medical measurements, which help health practitioners make diagnoses and detect toxic effects of medication, can also help people with HIV track their health. In this issue, Joe Eviatar, MD – a New York City ophthalmologist who, together with his associate Christopher Coad, MD, has treated many people with HIV – discusses recent eye examinations and surgery performed on his patient, *POZ* founder Sean O. Strub.

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As with many other PWAs, Sean's health has dramatically improved over the past two years. His CD4 count has now increased to 225 – from a low of just one in 1995 – and his viral load is undetectable on Crixivan (indinavir), d4T (Zerit) and delavirdine (Rescriptor). Because of his improved prognosis, Sean chose to undergo an elective surgical procedure to improve his vision and thus enhance his quality of life. (He was mildly nearsighted, with slight astigmatism, or distorted vision.) Sean had expressed interest in this after he noticed that I no longer required glasses or contact lenses following photorefractive keratectomy (PRK), a procedure that uses a type of laser called an excimer to correct myopia (nearsightedness) and astigmatism.

Sean was an excellent candidate for this FDA-approved procedure, since more than 95 percent of patients with his level of myopia achieve better than 20/30 vision – better than that required for driving. And although PRK surgery has not been studied in PWAs, our experience performing laser vision correction on numerous patients with HIV has been uniformly positive. There have been no significant problems with postoperative healing, and most no longer require visual correction after the procedure.

My associate Christopher Coad, MD, performed Sean's laser vision correction on his right eye; it took 30 minutes, with only eyedrops for anesthesia. Within a week Sean saw 20/20 with that eye. His left eye is only slightly nearsighted; thus he elected to forgo surgery in this eye so he can use it more comfortably for nearvision. He had no complications from the surgery (which cost about $2,000, not covered by insurance).

In the past, many PWAs have been dissuaded from having elective procedures because it was thought that their future prospects were too poor to warrant the cost, recovery time and, in some cases, pain of such surgeries. With today's improved outlook, such procedures should be offered to improve quality of life. There are, unfortunately, still physicians hesitant to perform any surgical

procedures on PWAs, but implementation of universal precautions should open this door. HIV positive people should be given the same chance to reap the benefits of such procedures enjoyed by the HIV negative.

PWAs must also, of course, continue their HIV-related vision care. I have continued to screen Sean about every three months for CMV retinitis. He has shown none of the signs or symptoms that might indicate this – floating spots, flashing, or blurry peripheral or central vision. However, many patients are found to have CMV retinitis even though they have no symptoms, making screening exams a must. Screenings should continue to be performed on patients whose CD4 count fell below 100 at any time, even if the counts later rose to higher levels. This is because it appears that the increased T-cells may not be as effective in combating infections. (See “The Eyes Have It?”). In addition to professional exams, weekly at-home use of an Amsler grid can improve the chances for early detection of CMV-related vision changes.

Sean has never taken the one drug approved by the FDA as a prophylaxis (preventive) for CMV retinitis – oral ganciclovir (Cytovene). This is not usually prescribed unless patients have CMV disease elsewhere, due to the significant toxicity and high cost of treatment, as well as the possibility of developing viral resistance to the drug. But any patient who has ever gone below 100 CD4 cells is at high risk for retinitis. Such patients should weigh the above disadvantages, as well as their access to quarterly screening examinations, in deciding whether to start prophylaxis.

If Sean were to develop CMV retinitis, there are now much better options for treatment. Vitrasert, a slow-release capsule implanted into the eye, directly delivers a high concentration of ganciclovir. It provides by far the best level of protection against recurrent retinitis. The half-hour surgical procedure requires only local anesthesia. The most hopeful aspect of the new treatments for both HIV and CMV is that they give patients more therapeutic options – especially important for dealing with recurrent retinitis in patients living longer. And in some cases, when effective antiretroviral combinations boost immune function over time, it appears that we can reduce or even eliminate CMV treatment.

For now, we continue to see Sean for screening examinations every three months. The vision in his right eye remains 20/20. It is my hope that some new approaches now being studied, including a CMV viral load test, will soon allow us to accurately predict if Sean is likely to develop CMV retinitis and should be given prophylaxis.

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