

VIEWPOINT

The Department of Ophthalmology Columbia University
at The Edward S. Harkness Eye Institute



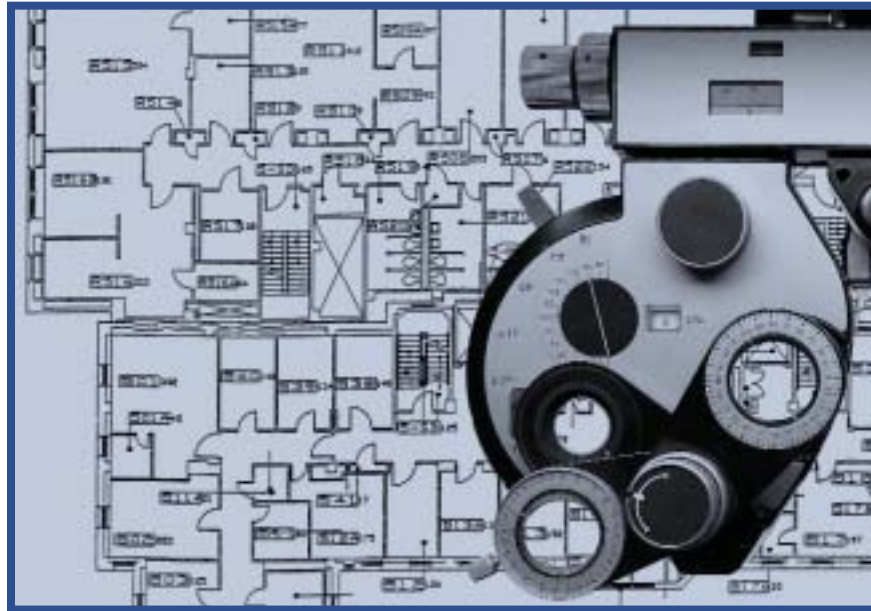
Fall
2000

Major Gifts Spark Clinical Research

Decoding the human genome is one of biomedicine's crowning achievements. Understanding life's structure at the molecular level will generate new opportunities for clinical applications to prevention and treatment of even the most perplexing disease, including those that affect vision.

A group of exceptional gifts totaling \$5.5 million, from Russ and Angelica Berrie, the Louis V. Gerstner Jr. Foundation, and the Starr Foundation, will place three new, interlocking programs devoted to clinical research for eye diseases on the 5th floor of the Department of Ophthalmology.

The Berrie's gift will establish The Russell Berrie Diabetic Retinopathy Research Unit, which is part of The Berrie Family Diabetic Retinopathy Program, a cooperative effort between the Naomi Berrie Diabetes Center and the Department of Ophthalmology. The Berrie Unit will be located in The Louis V. Gerstner, Jr., Clinical Research Center in Vision, underwritten by the Gerstner



Foundation, which will also house the Starr Foundation Retina Research Unit. Together, the Center's facilities form a sophisticated and comprehensive research complex dedicated to developing effective clinical solutions for vision problems, especially those affecting the retina.

Developing new strategies to save vision is even more critical, says Dr. Chang,

INSIDE:

CLINICAL TRIALS

VISION CORRECTION

LASER SURGERY

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Views from the Chair

Dear Friends:

The holiday season is a time to count one's blessings. This year, it gives me great pleasure to count among mine the realization of my dream to create a major clinical research program in ophthalmology at Columbia. Now, thanks to the generosity and friendship of The Louis V. Gerstner, Jr., Foundation, Russ and Angelica Berrie, and the Starr Foundation, we are launching just such a program.



Clinical research is one of today's most critical frontiers in medicine. Recent basic science discoveries are now destined for programs designed to ensure their safe translation into successful solutions for disease prevention and treatment. The Department of Ophthalmology's new Clinical Research Center in Vision is an important complement to our basic research efforts, because it provides a framework for developing novel sight-saving treatments to their full potential. The Center will allow us to fulfill many of the goals that are most important to our faculty and our patients.

I am also grateful for the increasing strength of our Retina Scholars Program. As reported in this edition of *Viewpoint*, Dr. Lucian Del Priore has joined our faculty as the first Burch Scholar in Retina Research. An outstanding physician and scientist, Dr. Del Priore brings with him the talent, training and experience needed to develop new options for vision restoration through retinal transplantation. I am delighted to welcome him to our Department.

I hope this holiday season gives you the opportunity to reflect on your own goals and achievements. May it be a time of health, happiness and realized dreams for you and your family.

With warmest wishes,

A handwritten signature in blue ink that reads "Stanley Chang". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Stanley Chang, M.D.
Edward S. Harkness Professor
Chairman, Department of Ophthalmology

P.S. My faculty and I extend our sincere appreciation to those of you who have responded with thoughtful gifts via the enclosure envelope found in all issues of *Viewpoint* and respectfully request that you consider the Department in your

Columbia Ophthalmology Remains at the Top in National Funding

Columbia's Department of Ophthalmology received over \$2 million in grants from the National Institutes of Health (NIH) in 1999/2000, maintaining its consistent ranking among top NIH award recipients. The Department's new Clinical Research Center in Vision is expected to increase funding opportunities for clinical studies as well as to facilitate and possibly to expand current research projects, some of which have been described in previous issues of *Viewpoint*. They include:

Genetics of Age-Related Macular Degeneration (*Viewpoint*, Fall 1999)

Clinical investigators Theodore Smith, M.D., and Gaetano Barile, M.D., are collaborating with the Louis V. Gerstner, Jr., Scholar Rando Allikmets, Ph.D., to search for genetic links to age-related macular degeneration.

Excimer Laser Surgery for Vision Correction; Bacterial Conjunctivitis

Richard Braunstein, M.D., recently directed clinical trials on the use of excimer laser surgery to correct hyperopia, both with and without astigmatism (see page 11), and of a new antimicrobial eye drop for patients with acute bacterial conjunctivitis.

Myopia (*Viewpoint*, Spring/Summer 1999)

Stanley Chang, M.D., and David Maberly, M.D., are investigating genetic and environmental causes of myopia or nearsightedness, a condition affecting one-quarter of Americans.

Confocal Scanning Slit Microscopy (*Viewpoint*, Fall 1997)

Charles Koester, Ph.D., Norman Kleiman, Ph.D., and James Auran, M.D., have developed the confocal scanning slit microscope, an instrument with important diagnostic potential that can examine tissue within the living eye at the cellular level. The researchers, who have already used the technology to examine tissue from the iris and cornea, will expand their studies to the lens and other structures in the eye.



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because the prevalence of eye disease is growing in an increasingly aging population. Estimates show that approximately half of those over the age of 70 will need cataract surgery, and a staggering 21 million Americans—one third of those over age 50—are at risk of developing age-related macular degeneration. Other serious disorders like glaucoma, which impairs the vision of as many as 2 million people, and diabetic retinopathy, which causes 8,000 new cases of blindness annually, also become more common as people age.

Columbia's Department of Ophthalmology is recognized worldwide for advancing eye care through scientific discovery. The first to use lasers in medicine, Columbia eye specialists also helped to develop key instrumentation for a more precise diagnosis of vision disorders, including the specular microscope and ultrasound, and were the first to use excimer lasers to correct nearsightedness and astigmatism. Columbia ophthalmologists also developed and pioneered: the use of perfluorocarbon liquids for correcting complex retinal detachment; the

substance, Healon, which is used worldwide to protect delicate tissue in the eye during surgery; and latanoprost, one of the most widely used drugs for treating glaucoma.

According to Dr. Chang, the new Center will offer a multi-pronged approach to the treatment of human disease, identifying at-risk patients and populations, facilitating gene-targeted pharmaceutical development, and making the use of gene therapy possible. ●

Construction and recruitment for the Clinical Research Center in Vision has been underwritten by the generosity of The Louis V. Gerstner, Jr., Foundation, Russ and Angelica Berrie, and the Starr Foundation. Additional support will be sought for the Center's continuing development. For information on how you can help, please call Susan Taylor, Senior Development Officer, at 212-304-7200.

Making Space and Building Programs for the Clinical Research Center

Renovation

The Clinical Research Center will be located on the Harkness Eye Institute's fifth floor, redesigned as an attractive, patient-friendly environment. The 8,500 square-foot space will incorporate comfortable, efficient examining rooms, waiting areas and offices, where state-of-the-art equipment will be used to diagnose and treat vision disorders. A "reading" center will allow doctors to view digitized images related to eye care transmitted from off-site locations.

Research Collaborations

Research collaboration will be forged with related programs at Columbia in the Departments of Genetics, Neurobiology, Bioengineering and the Mailman School of Public Health. Projects planned with partners from neighboring regional research centers should attract increased federal support. The Center will also build alliances with centers, both nationally and internationally, and will work with private industry to develop promising new treatments.

Clinical Trials

A team of skilled physician-scientists working with other specialists, including clinical research coordinators, epidemiologists, and statisticians, will use their expertise to design protocols for clinical studies, in keeping with both government and Columbia University regulatory policies.

A database will be developed for recruiting patients to clinical trials. Patients who fail to meet the criteria for one trial may thus be found eligible for other studies or research at a different facility.



Phasing in Safety and Success for Patient Treatment

Clinical trials are a very important part of clinical research. These carefully monitored studies require human participation, but only after extensive laboratory tests of the substances or treatments involved have shown that they will not harm those involved. Commonly asked questions and answers about clinical trials and how they work include:

What is a clinical trial?

A clinical trial tests newly developed medical treatments or new ways of using known treatments to determine if they are appropriate and effective when used on human patients.

What is a protocol?

A protocol is a set of rules to govern how a clinical trial is conducted. The protocol for a trial describes what types of people may participate in the trial; the schedule of tests, procedures, medications and dosages; and the length of the study.

What protections are there for people who participate in clinical trials?

The federal government has strict guidelines and safeguards to protect people who choose to participate in clinical trials. Every clinical trial in the United States must be approved and monitored by the Institutional Review Board (IRB) of the institution where the trial is located, to make sure the risks are as low as possible and are worth the potential benefits. Columbia-Presbyterian Medical Center has a highly regarded IRB, staffed by recognized medical experts, dedicated community advocates and experienced administrators to ensure that a clinical trial is ethical and the rights of study participants are protected.

How are trials conducted?

Typically, trials are launched by a medical center's clinical researchers or by pharmaceutical companies who develop a protocol for testing a new drug or treatment. Protocols are

proposed to Columbia's Pharmacology Unit and, if accepted, are then submitted to Columbia's IRB as well as the University's Office of Clinical Trials, which oversees clinical research programs. If approved, the Clinical Pharmacology Unit conducts the study, which is categorized as a Phase I, II, III, or IV trial, depending on the extent of previous testing.

What are the phases of a clinical trial?

Phase I: Researchers test a new drug or treatment in a group of about 20 to 80 people to evaluate its overall safety, determine a safe dosage range, and to identify side effects.

Phase II: The drug or treatment under study is given to a larger group of about 100 to 300 people to see if it is effective and to further evaluate its safety.

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Dr. Norman Kleiman, at right, uses a confocal microscope (see pg 3) during one phase of a clinical trial.



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Phase III: Researchers next test the study drug or treatment in a very broad sample—about 1,000 to 3,000 people—to confirm its effectiveness, monitor side effects, compare it to traditional treatments, and collect information that will determine the safest method for its use.

Phase IV: After the drug or treatment has received FDA approval and is commercially available, researchers continue to collect information about its effects in different populations, as well as any side effects associated with long-term use.

What is a placebo?

A placebo is an inactive substance that has no treatment value. Placebos are sometimes given to a “control” group of patients participating in a clinical trial while the actual drug or treatment being tested is given to another group. Researchers can then compare results drawn from patients receiving the placebo with those from patients who receive treatment to determine the treatment’s likely effectiveness.

Where are Columbia Department of Ophthalmology trials conducted?

Currently, patients who participate in a Columbia Department of Ophthalmology study may be evaluated and treated in the Harkness Eye Institute’s Flanzer Center at 165th Street and Fort Washington Avenue, or in the Merriam Center at 16 East 60th Street. Plans are under way to facilitate examinations at other sites throughout the city (see “Screening Foresight”) and to build a new clinical research center on the Harkness Eye Institute’s fifth floor (see “Major Gifts Spark Clinical Research”).

Why participate in a clinical trial?

Becoming part of a clinical trial may have some risks; there is the possibility of experiencing side effects, having a bad reaction, or simply not benefiting from treatment. There is also a time and convenience factor. Visits to study sites or to the hospital may conflict with other

obligations or may seem too demanding for some patients. (Some trials pay patients to participate, others may pay for transportation, child care, and meals or other costs.) In addition, dosage requirements can sometimes be complicated.

So, why should anyone join a clinical trial? Participating in clinical research offers many patients the opportunity to take an active role in their health care choices. Joining a trial may provide patients with drugs or procedures not otherwise available to them that can help alleviate distressing symptoms, or even cure the disorder from which they are suffering. Joining a trial also offers patients the benefits of obtaining healthcare at leading medical facilities, often at no personal expense. Finally, patients who join a clinical trial make an important contribution to the advancement of medicine that may, ultimately, help themselves as well as their friends, family, and generations to come. ●

Dr. Rando Allikmets, the Louis V. Gerstner, Jr., Scholar, in his laboratory, is investigating probable genetic links to age-related macular degeneration.





New Perspectives on Vision Correction

If you've ever misplaced your glasses, gotten a painful smidgen of dust under your contact lens, or searched the floor, inch by inch, in the hope of finding a dropped lens, you know the pitfalls of conventional vision correction. The reality is that relying on eyewear—be it nestled between corneal surface and lid or secured by ears and nose—can be a nuisance. So, when excimer surgery became available to treat myopia, the condition of nearsightedness that affects 70 million Americans, it's no wonder the procedure was heavily in demand from the start. More than 200,000 myopic patients opted to have laser vision correction in 1997, only a year after the surgery received Food and Drug Administration (FDA) approval. By 2001, the number of excimer laser surgery patients is expected to exceed one million. Among them will be those receiving the technology's newest improvements for treating hyperopia, or farsightedness.

Hyperopia occurs in about 25 percent of the population when light rays entering the eye fall behind,

rather than on, the retina because the eyeball is too short or the cornea is too flat. People who are farsighted have particular difficulty with activities like reading or sewing that necessitate seeing near objects. If, on the other hand, the eye is too long, or the cornea is too steeply curved, light rays fall short of the retina, resulting in nearsightedness or difficulty seeing into the distance. The goal of excimer laser surgery in the treatment of each of these conditions is to sculpt the cornea so that light rays reach their intended target, the light-sensitive retina.

Applying the excimer laser to vision correction is the brainchild of Stephen Trokel, M.D., Professor of Clinical Ophthalmology at Columbia University. During the 1980s, Dr. Trokel, a trained physicist, hypothesized that the laser, which was designed to etch computer microchips with exacting precision, could be used with equal accuracy on the human eye. The procedure he pioneered, photo-refractive keratectomy (PRK) involved using the laser to ablate or vaporize surface layers of corneal tissue. In a subsequent adaptation of PRK called

LASIK (laser-assisted *in situ* keratomileusis), surgeons use a motorized blade, or keratome, to cut an ultra thin, circular flap of tissue from the cornea. The flap, which is put back in place after laser treatment, acts as a protective cover that allows the eye to heal more quickly. Nearsightedness is corrected by using the laser to flatten tissue in the center of the cornea; farsightedness is corrected by removing a ring of tissue around the cornea's center to steepen its curvature. The laser can also treat astigmatism, caused by an irregularly shaped cornea, by vaporizing more

tissue on one side than on the other.

Last year, Columbia University became one of seven sites conducting clinical trials on the use of LASIK to treat hyperopia—both with and without astigmatism. According to the study's principal investigator, Assistant Professor of Clinical Ophthalmology Richard E. Braunstein, M.D., results were excellent. Prior to surgery, he reports, patients depended on contact lenses or glasses for all vision tasks. After LASIK treatment for hyperopia, most patients were free of glasses and contacts for distance vision, and

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Dr. Richard Braunstein positions a patient prior to excimer laser surgery.



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all showed improvements in reading without glasses. “Unlike those who are nearsighted,” says Dr. Braunstein, “people with hyperopia have no focal point, so without correction, their whole world seems blurred. Those we have treated are among our happiest patients.”

Excimer laser surgery is now a \$3 billion-a-year industry, according to a recent article in the *New York Times*. But, as popular as it has become, the procedure is not a solution to all vision correction problems. It cannot, for instance, be used to treat the kind of farsightedness that strikes adults in their 40s—presbyopia—a condition that occurs as the eye’s aging lens loses elasticity and focusing ability. The surgery can pose risks to patients with systemic conditions including diabetes, rheumatoid arthritis and other immunosuppressive disorders, and it should not be performed on patients whose corneas are abnormally thin, or those who have cataracts, glaucoma or severe myopia. For some patients, particularly those with large pupils, there is a postoperative risk that patients will experience nighttime

glare and see halos around lights.

Dr. Braunstein, who has conducted laser vision correction research since 1993 and has served as the principal investigator of three FDA-sponsored clinical trials for both PRK and LASIK surgery, emphasizes the importance of thorough patient screening by an experienced ophthalmologist and careful follow-up care. Often called upon to evaluate or treat patients who’ve experienced significant laser-related problems, he cautions: “The cornea is not made of plastic. It is biological tissue, with great variability from patient to patient. While you actually *can* go to a shopping mall to have laser surgery for your eyes, by doing so you may be taking the unnecessary risk of doing them irreversible harm. Yet, for most patients,” he adds, “LASIK, performed under the right conditions, offers new opportunities for better sight.” ●

For a consultation and more information, call (212) 326-3363 or (888) CVC-1660.

GIVING *Well*

Through the Giving Well program we offer you a number of ideas that can provide you with income and tax benefits and also fund the program or purpose you wish to support at the Eye Institute. One of these is the Charitable Remainder Trust (CRT), a life income gift you can tailor to maximize your personal tax advantages and to receive lifetime payments of income.

When you create a CRT, you transfer cash or other property to a trust which pays you, and/or another person, lifetime income. You select the length of the trust term, and you are entitled to an income tax charitable deduction in the year you create the trust.

There are two different types of CRT. A Unitrust pays you a percentage of the trust's assets, valued annually, with the potential for your income to grow as the principal grows. An Annuity Trust pays you a fixed amount, chosen when you create the trust. The annuity payment to you never varies, even if the value of the trust principal decreases.

If you choose, Columbia will act as trustee and manage your CRT investments for no fee, maximizing your benefits while minimizing the headaches to you. When your CRT terminates, the remaining principal is used for the purpose you choose, such as funding a fellowship or supporting important research.

We would be pleased to send you a copy of our brochure, "Giving Well," which describes CRTs and other life income gifts. We would also be happy to prepare a personal illustration for you. Please contact:

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Columbia University Health Sciences Development
100 Haven Avenue, Suite 29D
New York, NY 10032
TOLL-FREE- 1 (888) 277-9375
e-mail: givingwell@columbia.edu

Giving News: Thanks to Mr. and Mrs. Louis Flanzer, the Department of Ophthalmology will achieve two important goals this year. The Flanzers' generous \$500,000 gift provides for renovating the Eye Institute's amphitheater with state-of-the-art technology. The refurbished facility will be a resource for telemedicine conferencing and give viewers access to operating room procedures, both measures to support improved education and training for future physicians in the field. The Flanzers will also add to their unstinting support of the Eye Institute by providing \$100 thousand annually to underwrite two fellowships in the Department.



Screening Foresight

Most of us take vision for granted. But for the 16 million Americans stricken with diabetes, loss of vision is one of the most terrifying complications of the disease.

Diabetes is the most common cause of blindness in younger adults. The longer anyone has the disease, the greater the likelihood that the patient's eyes will be affected. In fact, say ophthalmologists, all patients who've had diabetes for

more than 20 years have some degree of related damage to their eyes. In about half of these patients, the damage is severe.

Early next year, Columbia's Department of Ophthalmology will inaugurate an innovative screening program, aimed at preserving the vision of patients with diabetes. Designed as a cost-effective way of reaching the large group of New



Dr. William Schiff, Director of Columbia's Diabetes Screening Program.

York City patients who may be vulnerable to diabetes-related vision loss, the program will employ the best known weapons for preventing blindness from the condition: early detection and tight glucose control. These techniques, says the new program's director, William Schiff, M.D., Assistant Professor of Clinical Ophthalmology at Columbia, have been shown to slow, and sometimes halt, disease development and progression.

Diabetic retinopathy, the retinal deterioration caused by diabetes, is a condition of multiple stages, brought on by excess sugars circulating in the blood of diabetic patients. The disease begins wreaking ocular havoc by attacking blood vessels in the retina, the thin, light-sensitive layer of tissue in the back of the eye. At this point, patients are often not aware of changes in their vision, but as retinopathy progresses, bleeding from fragile, new blood vessels growing on the retina's surface may blur or distort vision by obstructing light to the retina. Macular edema can also blur eyesight when damaged blood vessels leak and cause swelling in the macula, the part

of the retina used for activities like reading, driving, and discerning fine detail. At the disease's most advanced stage, scar tissue causes the retina to pull away or detach from the back of the eye, a problem that can cause blindness if left untreated.

Dr. Schiff emphasizes the importance of Columbia's new screening program in detecting eye problems before severe retinal damage occurs. By catching abnormal blood vessel growth and leakage early, it is possible to save the patient's sight with laser surgery. In addition, watchful regulation of glucose levels has been clearly shown to improve chances of avoiding these complications with a decreased risk of severe diabetic eye disease, regardless of duration of illness.

The Department of Ophthalmology's diabetes vision screening initiative will offer patients advanced and cost-effective technology acquired with resources provided by Russ and Angelica Berrie in the Berrie Vision for Diabetes Program for supporting work related to diabetic retinopathy.

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Staff at the Naomi Berrie Diabetes Center and at numerous clinical sites throughout northern Manhattan will be trained to capture retinal images with sophisticated digital photography. These pictures can then be transmitted for analysis and study to Columbia's diabetic eye disease specialists. Patients with a history of retinopathy, or in whom the condition has just been detected, will be referred to an ophthalmologist for further evaluation and treatment. The program's design offers important, practical benefits: retinal photographs can be taken at lower

cost, without the necessity of dilating the pupil, and during routine patient care visits. "New York has a large population of patients with diabetes whose eye complications go undetected," says Dr. Schiff, whose long-term goals include establishing diabetic vision screening programs at clinics and hospitals throughout the city, as well as developing a large data base of patients who may be eligible to join clinical trials. Speaking of the need to attack diabetic retinopathy head-on, he points to statistics that show that timely screening and laser treatment can result in an annual U.S. saving of hundreds of millions of dollars. "The cost of this disease is enormous, but even that pales when compared to its profound impact on patients and families. Diminished opportunities to work, travel, pursue hobbies, and otherwise enjoy simple pleasures are among the disease's life-altering hardships." Dr. Schiff predicts that "effective screening and prompt treatment may help to reduce these burdensome costs to individuals as well as to society." ●



Russ Berrie's Visionary Commitment

"I was diagnosed with diabetes when I was 32 years old. Like many people with the disease, I tried not to think about it. About five or six years ago, I noticed that newspaper type didn't seem large enough, a disturbing change that marked the beginning of a steady decline in my ability to see. Now, I can't recognize people from a distance. I can't drive. I can't read many of the documents that come across my desk in business. It is difficult and frustrating. But, I am fortunate to have help from those around me: my driver, my assistants at work, and my wife, who enjoys reading to me and

helps me in innumerable other ways.

"There is a tremendous need for supporting research and care in diabetes and its complications. That is why, four years ago, I decided to support the establishment of the Naomi Berrie Diabetes Center. Columbia's faculty and staff have been wonderful, and when I see people receiving compassionate, quality care at the Center, I'm thrilled. The real value of my investment in the Naomi Berrie Diabetes Center is the insurance that it might provide against the frightening loss of vision, not just for me, but especially for young people facing this lifelong battle against diabetes." ●

Lucian V. Del Priore

Named Burch Scholar

Columbia's Department of Ophthalmology has appointed Lucian V. Del Priore, M.D., Ph.D., an expert in retinal disease, to serve as Associate Professor of Ophthalmology and as the Department's first Burch Scholar.

A former Associate Professor of Ophthalmology and Neuroscience at the University of Medicine and Dentistry of New Jersey, Dr. Del Priore holds a Medical Degree with Distinction in Research from the University of Rochester and an M.A. and Ph.D. in Physics from Cornell. He completed his residency and fellowship programs at Johns Hopkins' Wilmer Ophthalmological Institute, where he specialized in glaucoma and vitreoretinal surgery, and then served on the faculty of Washington University School of Medicine for eight years. Dr. Del Priore is the recipient of numerous awards, including the Lew R. Wasserman Merit Award from Research to Prevent Blindness and the Honor Award from the American Academy of Ophthalmology.

Dr. Del Priore's recent investigations have centered on developing improved surgical techniques for treating the "wet" form of age-related macular degeneration (AMD). Characterized by the growth and subsequent leakage of blood vessels under the retina, wet AMD accounts for 90 percent of all blindness from the disease. "While there are current treatments for wet



AMD, including laser surgery and photodynamic therapy to cauterize leaking blood vessels,” says Dr. Del Priore, “these approaches help only about 15 percent of patients. We’ve been able to chip away at corners of the disease,” he adds, “but the basic questions remain: Why do unwanted blood vessels grow, and what can be done to eliminate their damaging effects?”

One potential solution he and fellow researchers are studying is retinal pigment epithelial transplantation, a procedure to replace the subretinal layer of tissue called retinal pigment epithelium (RPE) that is inadvertently removed with blood vessels during AMD surgery. Eliminating abnormal blood vessels from beneath the center of the retina is effective in treating patients whose ocular bleeding is caused by conditions other than AMD. But, says Dr. Del Priore, the surgery may not work for AMD patients because the RPE is removed at the time of surgery. The ultimate success of replacing RPE may lie in the transplanted cells’ ability to stick to another subretinal layer, called Bruch’s membrane, which is diseased in patients with AMD because the

RPE was removed at the time of surgery. His research, so far, has shown that transplanted RPE cells that adhere to Bruch’s membrane survive, whereas cells that do not, die.

But Dr. Del Priore suggests that the odds of cell-sticking and survival can be made more favorable by adding special “sticky” molecules to the “soup” that cells are placed in during RPE transplantation. This, he predicts could help cells cling to Bruch’s membrane—even when the tissue has been compromised by AMD. Collaborating with Peter Gouras, M.D., Professor of Ophthalmology at Columbia, whom he calls “one of the fathers of RPE transplantation,” Dr. Del Priore is exploring the development of just such a “super glue” strategy. He is also investigating other RPE transplantation techniques that may lead to improved methods of AMD treatment.

The Burch Retina Scholarship was established in 1998 by Robert L. Burch III. The award supports promising research by a gifted scholar in retinal disease. ●

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Family and friends of Stephen and Bjorg Ollendorff joined Columbia Ophthalmology faculty at the third annual Ulrich Ollendorff, M.D., Visiting Lecture, on May 18, 2000. The lecture, presented by Dr. Stephen M. Drance, Emeritus Professor of Ophthalmology at the University of British Columbia, on "The Management of Normal Tension Glaucoma," was followed by a reception and dedications of the Ulrich Ollendorff, M.D., Digital Imaging Center and of a sculpture, "The Gates of Wisdom, Understanding and Knowledge," by Israeli artist Aharon Bezalel. The sculpture was installed in the Eye Institute's lobby.

