

THE NEWSLETTER OF THE GLAUCOMA FOUNDATION

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THE GLAUCOMA FOUNDATION
116 JOHN STREET
SUITE 1605
NEW YORK, NY 10038
212-285-0080
FAX: 212-651-1888
TOLL FREE: 1-800-GLAUCOMA
(1-800-452-8266)

WEBSITE: www.glaucoma-foundation.org

E-MAIL:
info@glaucoma-foundation.org

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***With less than 30 minutes of your time, you can become
an active member of a time sensitive letter campaign that
could make a huge difference in preserving vision.***

***Please visit our website www.glaucoma-foundation.org or call
Christine Pipchick at 1-800-GLAUCOMA for information.***

Eye to Eye is published quarterly by The Glaucoma Foundation to help our readers better understand glaucoma, its causes and treatments. While every effort is made to ensure the accuracy of this information, please consult your eye doctor for treatment and care of your eyesight.

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ANNETTE GOLIA
Editor

ERIC NEUNER &
NOELLE GRAF
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The Glaucoma Foundation
116 John Street, Suite 1605
New York, NY 10038

212-285-0080 or
1-800-GLAUCOMA

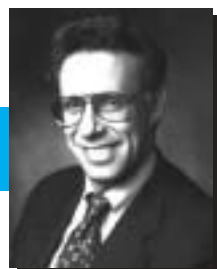
FAX: 212-651-1888

e-mail: info@glaucoma-foundation.org
Web Site: www.glaucoma-foundation.org



From the Desk of the Executive Director

By John W. Corwin



We're off and running! It's a new century, a new millennium, and The Glaucoma Foundation is wasting no time making strides to eradicate this insidious disease that steals vision from so many millions. With so much to cover, this is a special expanded edition of *Eye to Eye*.

The main feature of this issue, "Glaucoma: Yesterday, Today and Tomorrow," shows us how far we've come in understanding the complex diseases — yes, the multiple diseases — we call glaucoma. On the research front, you'll want to read about the new investigations being underwritten by our Research Grant Program.

The goal of research is to find better ways to help glaucoma patients, treat glaucoma, and one day cure glaucoma. The search for new treatments begins in the laboratory, where scientists first develop and test new ideas. The final step for a new drug or therapy is a clinical trial with people to study whether the promising treatments are safe and effective. For more about clinical trials, see our "Doctor, I Have A Question" column beginning on page 12.

On the outreach front, The Glaucoma Foundation is proud to host the first annual GLAUCOMA 2000 Symposium, an all-day meeting targeted to both patients and health professionals. On Friday, April 7 in New York City, world-renowned specialists will discuss the latest treatments for glaucoma, including complementary and potential genetic therapies. For those readers who live in the tri-state region, it may not be too late to sign up. Call (212) 651-2503 for more information. The next newsletter will cover highlights of the symposium.

In January, we kicked off the century with a busy National Glaucoma Awareness Month. Recognizing that more consumers are getting empowering information through the Internet, our all-important message "get your eyes examined to prevent blindness from glaucoma" showed up in half a million web banners targeted to sites predominantly used by African Americans and people over 45 years of age. Additionally, our message was picked up by web media outlets: both Foxnews.com and

Ophthalmology.about.com carried on-line interviews with Glaucoma Foundation representatives. And that's not all — family magazines, national television (CBS Saturday Morning), national radio (American Urban Radio Network), newspapers, TV and radio stations in the New York metropolitan area all helped us to spread our early detection campaign across the nation.

Our cyberspace stories and banners also featured hot-buttons connecting with The Foundation's web address — www.glaucoma-foundation.org. If you haven't visited our newly revamped, interactive site, stop by soon. There are new features every month, and we try to update it with breaking news whenever possible. It's a great way to stay in touch with what's happening. For example, log on to our website to join a new advocacy campaign to have Medicare insurance cover preventative glaucoma examinations for at-risk Americans.

For the past seven years, it has been a distinct privilege for all of us on staff to serve under the

remarkable leadership of Joseph M. La Motta, Chairman of the Board of Directors. He has been a driving force behind The Foundation's growth, evidenced by such visionary programs as the Community Outreach Screening Program (COSP),

Young and Under Pressure (YUP) and our International Think Tank on Optic Nerve Rescue and Restoration. A glaucoma patient himself, Joe has dedicated himself to advancing The Foundation's twin missions of research and public education. We thank him for his years of voluntary service which have helped so many. Joe has turned over the reins

to a talented and able successor, Gregory K. Harmon, MD. Read about Dr. Harmon on Page 4.

And now, I turn to you — our friends and supporters. Only with your continued contributions can The Glaucoma Foundation increase activities and make headway on so many fronts. Your donations — large and small — make all the difference. We hope we can count on your continuing support. Thank you.

The main feature of this issue, "Glaucoma: Yesterday, Today and Tomorrow," shows us how far we've come in understanding the complex diseases — yes, the multiple diseases — we call glaucoma.



ON AIR — Keep an eye out for Linda Lopez (left), shown here at Cablevision's Long Island studios with Christine Bragan (right), Community Affairs Manager. Linda is The Glaucoma Foundation's spokesperson in a new television public service announcement (PSA) alerting viewers to the need for routine eye examinations. The PSA was produced through the generosity of Cablevision, one of the nation's largest cable operators.

TGF Names New Board Chair



Joseph M. La Motta
TGF's Incoming Chairman
Emeritus



Gregory Harmon, M.D.
TGF Board Chairman
and CEO

Gregory K. Harmon, MD, a senior member of The Glaucoma Foundation Executive Committee, was elected the new Chairman of the Board of Directors and Chief Executive Officer of The Foundation. He succeeds Joseph M. La Motta, who after seven years in the voluntary position takes on the new post of Chairman Emeritus.

"Greg Harmon is totally committed to the mission of The Foundation and the fight against glaucoma," said La Motta. "His years of Board experience and his dedication make him ideal to lead The Glaucoma Foundation."

A highly-regarded ophthalmic surgeon, clinician and researcher specializing in glaucoma, Dr. Harmon has been a Board member since 1992. He has chaired several key committees, including the Medical Advisory Board and the Public Relations Committee. He also served as Gala Chair of the 1999 Black & White Ball, raising a record sum for The Foundation's research and education programs.

Intent on heightening public awareness about the need for regular eye examinations to detect this "sneak thief of sight" before irreversible vision loss occurs, Dr. Harmon is credited with initiating public service announcements for The Foundation, including one featuring the actress — and glaucoma patient — Kitty Carlisle Hart, educating millions of

television viewers about glaucoma.

"As Chair, I plan to devote considerable energy to fulfilling the legacy of the Joseph M. and Geraldine C. La Motta Endowment Fund for Glaucoma Research," said Dr. Harmon. "Reaching our \$5 million campaign goal not only will ensure a permanent funding source to continue underwriting vitally-needed research, it also will salute the couple who had the foresight to see the need for such a fund."

"By educating ourselves more about the disease and spreading the word . . . we can make incredible strides to detect glaucoma early and, eventually, eradicate blindness from glaucoma."

— GREGORY K. HARMON, M.D.

"Every one of us can help advance our goal of a world without blindness," said Dr. Harmon, noting that his second goal will be to substantially expand public involvement in The Foundation's mission.

"This new century holds much promise in the fight against glaucoma. By educating ourselves more about the disease and spreading the word — especially to those who are at higher risk — we can make incredible strides to detect glaucoma early and, eventually, eradicate blindness from glaucoma." Dr. Harmon suggested "making a donation at a Foundation event or honoring friends or loved ones with gifts in their name," as one way to contribute, adding "you can also support our public information campaign by reaching out in your own community with sight-saving information."

Professionally, Dr. Harmon is Director of Glaucoma Services of the New York Presbyterian Hospital, a post he has held since 1990. He also is Associate Professor of Ophthalmology at the teaching hospital. A native of Baltimore, Dr. Harmon graduated with honors from Johns Hopkins University in 1978 and received his medical degree from Mt. Sinai School of Medicine in 1982.

Following a medical internship at St. Lukes-

Roosevelt Hospital, he completed both his ophthalmology residency and glaucoma fellowship training at the New York Hospital-Cornell Medical Center.

Dr. Harmon also is a research investigator, seeking new ways to better diagnose and treat the disease, and he is the author of numerous medical publications, abstracts and book chapters dealing with glaucoma.

Most Recent Grant Awards

By Robert Ritch, M.D. 

Ethan Bier, Ph.D. - University of California, San Diego

Molecular genetic analysis of human disease associated Cytochrome P450 proteins involved in primary congenital glaucoma in Drosophila

CYP1B1 is a gene responsible for most congenital glaucoma. It is not known what the function of this gene is in lower animals. The fruit fly, *Drosophila*, has been a mainstay of genetic research for a generation. Most genes found in humans are found in *Drosophila*, where they may perform other functions. For instance, the gene responsible for glaucoma in Rieger syndrome is involved in development of the intestine in *Drosophila*. This study, by a leading *Drosophila* researcher, will look for the CYP1B1 gene in *Drosophila* and investigate its role in development.

Leonard A. Levin, M.D., Ph.D. - University of Wisconsin Medical School

Role of mitochondrial permeability transition in retinal ganglion cell death (renewal)

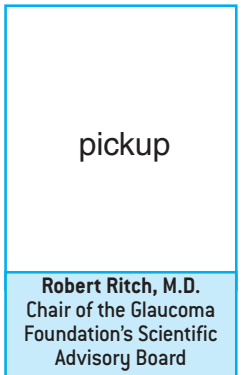
Mitochondria are the energy factories of a cell.

When cells begin to die, the mitochondria stop producing energy and start to self-destruct. Keeping mitochondria healthy may be another way to prevent the death of the optic nerve cells in glaucoma. Dr. Levin's grant is a continuation of a study regarding the role of mitochondria in the death of optic nerve cells.

Joanne A. Matsubara, Ph.D. - University of British Columbia

Effects of elevated intraocular pressure on the central visual pathways in a primate model of glaucoma

Almost all studies on glaucoma have looked at the cells of the optic nerve. The nerve cells connect to the visual cortex in the brain. By looking at the effects of elevated intraocular pressure on the visual pathways in the brain, Dr. Matsubara's research will hopefully uncover what happens to the cells of the brain when the cells responsible for carrying the visual impulses to them die, and whether these cells die because there's nothing for them to do.



Robert Ritch, M.D.
Chair of the Glaucoma
Foundation's Scientific
Advisory Board

GLAUCOMA: YESTERDAY, TODAY & TOMORROW

A SPECIAL FEATURE

Living with Glaucoma

By Annette Golia

LIVING HALF A LIFETIME WITH GLAUCOMA: JOHN B. HALSTED'S STORY

I have had glaucoma for more than 34 years, having been diagnosed in 1965 at age 39. My wife, who in the late 1940's had provided occupational therapy for the blind, helped prepare me for what I faced. She made clear how I should administer my own eye drops, and kept me aware of how much better my treatments were than those of 20 years earlier.

I was monitored through regular visits to doctors and I developed a strict ritual of medication. I have used both eye drops and pills; dropping some after adverse reactions. I kept my vision without significant loss for almost 20 years.

In 1984, when laser procedures became available, they were performed on both eyes to control rising IOP, and then had to be done a second time. When these efforts did not work to control my pressures and stop vision loss, a series of

trabeculectomies was performed.

The first trabeculectomy on my left eye resulted in a temporary collapse of the chamber. Then, from 1984 to 1988, I had in sequence: a trabeculectomy on my right eye, revision surgery on the right trabeculectomy, cataract surgery on the left eye, a trabeculectomy revision on the left eye that was followed by a retinal hemorrhage, and a second revision on the right eye. In 1991 I had cataract surgery on my right eye and in 1997 laser surgery was performed on the capsule of the artificial lens of my left eye.

1999 was a year dominated by treatments for the right eye. To lower pressure, another trabeculectomy was tried but failed due to past scarring. Further trabeculectomies were out of the question; my only options were little used procedures to reduce the production of fluid.

In April, a new laser procedure was performed with apparent success. Prior to it, medication could only hold the pressure to 40; recently, the pressure read 13.

I now take what is considered "maximum medication" — five different eye drops on three schedules. Despite my vision loss, with glasses my left eye can read the chart at better than 20/20 and the right, with difficulty, has read at 20/30. I have kept my driver's license, but would drive only in an emergency.

I have seen impressive advances in the treatment of glaucoma. Before our modern sophisticated machines, my pressures were read mechanically and visual fields were checked using a lighted stick against a black cloth backdrop. My earliest laser surgery came soon after that procedure was introduced. My first trabeculectomy required a painful injection of the anesthetic directly into the eye. In later operations, an IV drip put me to sleep, allowing painless injection of the anesthetic. I received new treatments, such as an experimental disc to bring the pressure up when a chamber collapsed, and 5FU injected into the eye to inhibit scarring during a trabeculectomy revision. As new medications have appeared, I have used them. I expect such progress to continue. For instance, I hear of promising new research on how cells die which may lead to knowledge of how vision loss occurs.



GLAUCOMA: YESTERDAY, TODAY & TOMORROW

There are also many new resources to make reading, typing, using computers, and other activities easier to those with vision loss. When glaucoma made reading difficult, the Dean at my college set up a fund for enlargement of reading assignments and bought an enlarging program for my word processor. When I reached age 60 a phased retirement program allowed me to teach part-time to age 70.

Such support from colleagues, the crucial assistance of my wife, and the skill and concern of my doctors have helped make manageable the problems the disease presents. At crucial stages, I was too busy focusing on my treatment to be optimistic or pessimistic about the outcome.

Managing glaucoma, like diabetes, demands constant attention. I find that by learning about it, noting my symptoms and working with my doctors I have more sense of control and a more positive outlook. We can judge best our subjective

experience and can tell our doctors about aspects of the disease they cannot measure. We probably know much of our medical files better than they. Treatment becomes something we do with them, not something they do to us.

With sight continuing more than 30 years after diagnosis, I can serve as witness to increasing success in the care of the disease. The object, after all, is to see as long as we live.

Managing glaucoma, like diabetes, demands constant attention. I find that by learning about it, noting my symptoms and working with my doctors I have more sense of control and a more positive outlook.

Glaucoma: It's a Family Affair




GLAUCOMA: YESTERDAY, TODAY & TOMORROW

By Julia E. Richards, PhD

Not everyone with glaucoma has a family history of the disease. But it is surprising how many patients find it lurking in their family trees if they go looking for it. In recent years, genetics researchers in more than a dozen labs on three continents have been sorting through the family histories of people with glaucoma in search of answers to questions about the underlying causes of the disease. And one of the answers they have found is that people with a family history of glaucoma can play a role in the search for the answers we need to save sight and put an end to glaucoma.

Have you ever wondered what a gene is or what it has to do with you? Each of us has two copies of a genetic blue-print inside of each cell. That duplicated blue-print contains directions for the production of each of the molecules and structures in our cells, along with directions for the activities that take place in those cells. Separate pieces of information within that blue-print are what we call genes. Amazingly,



JULIA E. RICHARDS, PH.D.

Member of
TGF's Scientific
Advisory Board
Senior Associate
Research Scientist
Department of
Ophthalmology
& Visual Sciences
Department of
Epidemiology
The University
of Michigan
W.K. Kellogg
Eye Center

more than 99% of the information in your blue-print is identical to the information in other people. But some of the important differences between people result from "typos" in the blue-print (mutations). Some of these typos cause errors that can make some essential function or structure in the cell go awry and lead to diseases like glaucoma.

If you happen to have a typo in a glaucoma gene, you might find not only that you have glaucoma, but that other members of your family have it, too. Why? Because one of your blue-print copies came from your mother and one came from your father. If your mother had a typo in a glaucoma gene, then she would have passed the good copy to some of her children

and her typo copy to others. Similarly, genetic blue-prints passed down through a family may have spread a typo in a glaucoma gene to descendants of long-lost ancestors.

But glaucoma isn't always inherited. So why do we care about family history? Because genetic studies of people with a strong family history of glaucoma can lead to key breakthroughs in the search for glaucoma genes. Finding their particular glaucoma gene, and finding out what problem is being caused by the error, can give us some valuable tools. It can tell us about the normal processes that should have been carried out by the glaucoma gene and point to the molecules and cellular processes that have been disrupted by the typo in the glaucoma gene. This in turn gives us a handle on new approaches to the disease.

Approximately two million Americans with glaucoma don't even know that they have it. Imagine how many people could be affected by a test that would predict glaucoma before the very first events in the disease. Imagine using treatments that target the real cause of the disease, at the beginning, treatments that might even have the ability to keep the disease from ever starting in the first place. And then imagine finding key answers to how genes control later events in the disease, like death of cells in the optic nerve, and imagine being

Approximately two million Americans with glaucoma don't even know that they have it. Imagine how many people could be affected by a test that would predict glaucoma before the very first events in the disease.

able to target medical therapies at these later events after the damage has started. The key to these critical points in the disease — the initiating events that start the ball rolling, and the later events that cause the damage— is understanding the underlying causes. A powerful way to go after the causes is to go after the genes.

The answers to glaucoma may be different for different people— not surprising since glaucoma really is

multiple diseases. Many think finding glaucoma genes means that the next step is developing gene therapy. But an understanding of the processes by which the disease begins or progresses might also offer clues to simpler ways to approach glaucoma through medications or perhaps vaccines. So one of the key ways to get the answers that will give us improved approaches to both diagnosis and therapy is to find the genes. And one of the real keys to finding those genes, is finding people with glaucoma to participate in genetic studies.

So look at your family tree and ask yourself whether glaucoma runs in your family. And if it does, and you want to help, ask The Glaucoma Foundation or your doctor about ways you could contribute to the effort to find glaucoma genes. Turn your efforts into future tools in the battle against glaucoma.

The Present and Future of Diagnostic Testing in Glaucoma

By Murray Fingeret, OD

The diagnosis and management of glaucoma was, for many years, based upon elevated intraocular pressure (IOP), abnormal optic nerves, and visual field loss. Within the last ten to fifteen years, however, it was recognized that IOP is not part of the definition of glaucoma, but the leading risk factor for developing it. This leaves damage to the optic nerve and visual field loss as the primary signs of glaucomatous damage, and both are used to establish the diagnosis as well as monitor for stability or change in the condition over time.

Evaluation of the optic nerve involves a physical analysis of the eye that is damaged by glaucoma. The direct ophthalmoscope was the first tool used to get this image, but has many shortcomings. A dilated exam of the interior surface of the eye (fundus lens evaluation) using a biomicroscope, along with photographs of the eye's interior surface, has become the best method for optic nerve assessment and record documentation.

Two different optic nerve imaging devices, the Heidelberg Retinal Tomograph (HRT) by Heidelberg Engineering and GDx by Laser Diagnostic Technologies, have become increasingly used in clinical practice. Each allows a detailed analysis of the optic nerve and/or

surrounding retinal tissue.

While scanning the optic nerve and surrounding retinal tissues, the HRT uses a laser beam and a mirror-like surface to reflect images off the structures being examined. These images are reconstructed to create a three-dimensional picture of the optic disc, allowing measurements of the cup-to-disc ratio, cup volume, and an estimate of the amount of nerve tissue. These tests assist the doctor in determining if damage is present and in following changes over time.

The GDx, also a non-invasive method, measures the thickness of the nerve fiber layer (the nerve fibers carrying the visual impulses to the brain). The instrument directs a laser beam into the eye and measures the rate at which the light is reflected off the retinal tissues. The more the light is delayed, the thicker the nerve fiber layer. The resulting thickness measurements are then compared to a healthy nerve thickness. Other factors that may also cause the light to be delayed — which in certain situations could affect the results of this



MURRAY FINGERET, O.D.,
Member of TGF's Board
of Directors & Medical
Advisory Board
Chief, Optometry Section
Department of Veterans
Affairs, Brooklyn V.A.
Medical Center

test — are the subject of ongoing research.

Functional vision loss is measured by a perimeter (device which measures field of vision). This involves a small spot of light, which is placed in the visual field. Each eye is tested separately and the patient responds by pushing a button as each light is seen. The first visual field test was the Goldmann perimeter, which proved to be awkward for both the doctor and the patient. About twenty years ago, an instrument was introduced that allowed the visual field process to become automated and measurements to be repeated in various offices (static automated perimetry). But still, the test was long (12-16 minutes per eye) and difficult for many

to perform. SITA, the Swedish Interactive Thresholding Algorithm, represents a recent improvement for Humphrey perimetry, in which testing time is reduced by half without any loss of accuracy.

One remaining concern (and double-edged sword) about visual field testing is that a certain amount of optic nerve damage has to occur before visual loss is noticed. Two newer forms of perimetry — which detect visual field defects earlier on — have recently become commercially available. Short wavelength automated perimetry



GLAUCOMA: YESTERDAY, TODAY & TOMORROW

(SWAP) uses a bright yellow background and a large blue target to test a smaller group of retinal ganglion cells, the cells which die in glaucoma. Frequency Doubling Technology (FDT) perimetry from Humphrey-Welch Allyn, uses grating or shading patterns of black and

white bars. These bars rapidly flicker, meaning the black bars gradually become white and the white bars gradually turn black. This creates an illusion that allows only a small set of retinal ganglion cells (M cells) to respond.

In a series of studies, both SWAP and FDT show the ability to detect early glaucomatous loss — loss that would not yet be detected on routine visual field devices. But, both tests are new and still evolving. For example, the presence of a cataract can diminish

SWAP's effectiveness. Presently, further research is being performed to determine whether these tests should become part of the regular glaucoma eye exam.

Our future is promising. As our knowledge of glaucoma continues to increase, hopefully so will our ability to develop tools that permit earlier diagnosis of the disease. Earlier diagnosis, for many, is the key to preserving vision. Furthermore, as we continue to improve our abilities to analyze the optic nerve and measure functional vision, we hope to improve the detection and management of glaucoma.

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DOCTOR, I HAVE A QUESTION!

ABOUT CLINICAL TRIALS

With Guest Medical Expert Dr. Gregory K. Harmon

Since this issue of Eye to Eye focuses on the future, we think it's important for you to know how glaucoma research is shaped. Nearly all treatments — including drugs and medical devices — require clinical trials and approval by the government's Food and Drug Administration (FDA). We hope the following column provides you with insight into this process.

Q: What are clinical trials?

A: Clinical trials are research studies conducted with people to find better ways to diagnose, prevent and treat disease. These studies are done on human patients to evaluate whether the new treatment, procedure or device is safe and effective.

Q: What is the Food and Drug Administration?

A: The FDA is the federal agency which regulates the food we eat and the medicines, medical devices, cosmetics and radiation-emitting products we use. This helps to ensure safety, effectiveness and proper product labeling. Feed and drugs for pets and farm animals are also included within its jurisdiction.

Q: What is the FDA's role in glaucoma-related clinical trials?

A: The FDA's 2100 scientists review test results

submitted by the developers of all medications and medical devices to determine whether clinical trials are warranted. Additionally, the administration approves the action plan (known as the protocol) and the team of researchers selected to conduct the research. Final approval by the FDA, post-trials, determines whether the product can be made available to the public.

Q: What steps are involved in FDA approval?

A: Before the new medication or device is approved for public use, it must be tested in a three-phase process (see chart on page 13*) by investigators who must follow strict scientific and ethical principles. After successfully completing these phases, the developer is required to file a "New Drug Application" (NDA) or a "Pre-Market Application" (510K) with the FDA. The submitted report (which discloses

the results of all studies and manufacturing details) is analyzed by an appointed committee to determine whether final FDA approval will be given.

** This chart is from a special report from the FDA's Center for Drug Evaluation and Research*



GLAUCOMA: YESTERDAY, TODAY & TOMORROW

	PHASE 1	PHASE 2	PHASE 3
Group Involved	20-100 healthy volunteers	Up to several hundred patients	Several hundred - several thousand patients
Length of Phase	Several months	Several months - 2 years	1- 4 years
Purpose	Mainly safety	Some short-term safety, but mainly effectiveness	Safety, effectiveness and dosage
% Which complete the phase successfully	70%	33%	25-30%

Q: What happens in a clinical trial?

A: Patients are assigned at random to either a control or treatment group in order to avoid bias and assure more objective results. People in the treatment group receive the new drug or are treated with the new device; the control group participants receive a more standard treatment, no treatment or a placebo (a look-alike that has no active drug).

Q: How long does it take a new medication to receive FDA approval?

A: Taking into account early lab testing (pre-FDA approval), completion of all clinical trial

phases and review of the NDA or 510K, the average time to get a new product approved is eight and one-half years.

Q: What percentage of tested drugs or devices actually receive final approval for public use?

A: Approximately 20%.

Q: What happens after FDA approval?

A: Upon final FDA approval, the product can be placed on the market, where further studies on select patients are conducted to collect safety data and confirm clinical benefits. Over the product's lifetime, reporting and inspections are reviewed by the FDA.

(continued on next page)

DID YOU KNOW...

- Clinical trial results did not factor in gender differences until 1993.
- It only costs tax payers \$3 per person, annually, to fund the FDA.
- Prior to 1931 the FDA was named the Food, Drug and Insecticide Administration.

DOCTOR, I HAVE A QUESTION...ABOUT CLINICAL TRIALS

(continued from page 13)

Q: Where can I get more information about clinical trials?

A: If you or someone you know is interested in learning more, 1) Communicate with your doctor. Because small groups and select doctors are involved with trials, don't expect your doctor to have specific details on each study. But asking questions about your glaucoma and your involvement with a study should be top on your list. 2) Be sure you understand that expressing trial interest does not guarantee involvement nor does it guarantee that you will be included in the treatment group. 3) Try these resources: the FDA (www.fda.gov or 888-463-6332), the National Eye Institute (www.nei.nih.gov/neitrials/index.htm or 301-496-5248), Pharmaceutical Research and Manufacturers of America (www.phrma.org or 202-835-3400) and CenterWatch (www.centerwatch.com or 617-856-5900).

Look for our summer edition of Eye to Eye, in which we'll highlight some of the glaucoma drugs currently in phase 3 clinical trials.

PLEASE NOTE:

The information contained in this newsletter is meant to help you be a knowledgeable patient, not to endorse nor encourage involvement in clinical trials.

It is not The Glaucoma Foundation's role to endorse any product, treatment or surgery, but to help you identify and understand your options. If you are interested in learning more about clinical trials, please discuss this option with your doctor(s) before making any decisions.

A Thank You to Our Donors



(GIFTS RECEIVED SEPTEMBER 11, 1999 THROUGH DECEMBER 31, 1999)

The Glaucoma Foundation rounded out the last century with a photo finish, as the Thirteenth Annual Black and White Ball raised more than \$1.3 million in gross revenues, with a net income of over \$900,000. Under the leadership of Dr. Gregory K. Harmon as Gala Chair, and the extraordinary and unparalleled efforts of George F. Aquila and Jolene P. Mirena, the elegant dinner dance featured the famed Broadway Show "Guys and Dolls," as 700 guests toasted the honorees of the evening. With CBS-TV's Dana Tyler as the emcee, The Foundation paid tribute to:

❖ **Kitty Carlisle Hart**, the celebrated actress and singer, whose public service announcements have urged millions to get tested for glaucoma. At this Ball, The Foundation established the Kitty Carlisle Hart Award of Merit for Lifetime Achievement.

❖ **Erik Weihenmayer**, a 30-year-old mountain climber who is blind from glaucoma and has scaled five of the world's seven tallest peaks. Erik became the inaugural recipient of the Kitty Carlisle Hart award, and Mrs. Hart was on hand to present the award.

❖ **Marty Lewis**, for his consistent dedication and generous support. Marty serves as the Chair of The Foundation's Major Gifts Committee and sets an example of energy and commitment for all Board members.

❖ **Joseph M. La Motta**, who was for seven years the Chairman of the Board. His vision, tenacity, unflinching good judgment, and talented leadership have brought The Glaucoma Foundation from its modest beginnings to its position of pre-eminence today in the battle to eliminate the "sneak thief of sight."

(continued on page 16)

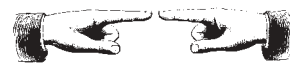


Special guest Kitty Carlisle Hart (center) presented the first Award of Merit for Lifetime Achievement, created in her honor, to Erik Weihenmayer, world class adventurer, athlete and mountain climber. With Ms. Hart is Gala Co-Chair Barbara Willis Hearst and Gala Chair Gregory K. Harmon, M.D.



Honoree Erik Weihenmayer, with his wife Ellen (left) and Gala Co-Chair Jolene P. Mirena (right)

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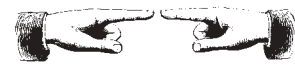
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Thirteenth Annual Black & White Ball



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- 1998 Annual Report
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No. 30

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