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Issues in Medicine: Equity and Site Neutrality

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Healthcare costs in the United States are notoriously complex and often exorbitant. One particularly contentious issue revolves around the discrepancy in outpatient charges between hospital-based facilities and private practices. Retina specialists, who treat a range of complex eye diseases, provide a compelling case study to explore this discrepancy.

The difference in facility fees—additional charges that hospitals impose for outpatient services—plays a significant role in the cost disparity for identical services based on the location of service. Here, I will delve into the economic implications of facility fees, comparing charges for retina specialists in hospital-based outpatient settings vs private practice, and examine the broader impact on patients, providers, and the healthcare system.

Facility fees are additional charges imposed by hospitals to cover the overhead costs associated with maintaining their facilities. These fees are billed separately from the professional fees that physicians charge for their services—and in many instances are not disclosed to the patient before care delivery.

In theory, facility fees help hospitals cover the cost of equipment, administrative support, and maintenance of a safe and sterile environment. However, they can significantly inflate the overall cost of outpatient care—and in many instances dwarf the physician costs. Care in a hospital-based outpatient department (HOPD) essentially generates a 2-part bill for the patient.

The physician-based bill is typically what the patient expects—a bill for the doctor's services; however, the second part, the facility fee, is often misunderstood and an unwelcome surprise for the patient. For patients, care delivery may be indistinguishable between the HOPD-based practice and the private practice. Remember that for office-based care, the overhead costs—supplies, staff, and equipment—are included in the physician's fee and are billed as a single service.

HOPDs virtually always charge significantly higher fees than private practices delivering care in an office-based setting (Figure 1). Facility fees are a primary driver of this cost difference. For retina specialists, the costs associated with diagnostic tests, treatments such as intravitreal (IVT) injections, and follow-up visits can be considerably higher in a hospital setting because of the 2-part billing for the physician service and the facility fees.

In contrast, private practice non-ophthalmic physicians typically have lower overhead costs. Ophthalmic care in general, and retina specialty care in particular, is often associated with high overhead costs related to the critical need for in-office imaging and same-visit treatment. (Think optical coherence tomography angiography [OCTA], spectral-domain OCT, multichannel imaging, and multiple staff as well as lane costs.) This supports retina specialists' ability to definitively manage the patient in the office encounter without having to send out for labs, x-rays, or computed tomography/magnetic resonance imaging as in a typical medical practice.

Photo courtesy of Kevin Caldwell Photography.

These overhead-cost-intensive retina specialty practices are currently not allowed to charge differently from low-overhead physician practices. The absence of facility fees makes office-based care significantly more affordable to both the patient and the healthcare system but greatly increases service-based expenses for the physician practice.

Private practices often operate more efficiently, with lower administrative costs and less bureaucracy; however, these efficiencies are typically outweighed by practice costs. With declining physician reimbursement, delivery of this care may not be possible in an office setting. Nonetheless, office-based care typically translates into significant savings for patients without compromising the quality of care.

Patients receiving care from HOPDs often face higher out-of-pocket costs. Even with insurance, facility fees can result in

CPT Code	Description	Professional Charge	Professional Medicare Allowable	HOPD Charge	HOPD Facility Fee Medicare Allowable	Combined Medicare
Academic Center (Hospital Based)						
99214	Level 4 Established	$299	$93.80	$291	$128.87	$222.67
92134	SD-OCT	$105	$17.14	$741	$59.50	$76.64
92250	Fundus/Autofluorescence	$88	Bundled	$1216	Bundled	
76512	Echography (bilateral)	$386	$58.22	$1792	$425.36	$483.58
Total		$878	$169.16	$4040	$613.73	$782.89
Private Practice (Office Based)						
99214	Level 4 Established	$299	$125.18	n/a	n/a	$125.18
92134	SD-OCT	$105	$31.38	n/a	n/a	$31.38
92250	Fundus/Autofluorescence	$88	Bundled	n/a	n/a	
76512	Echography (bilateral)	$386	$92.52	n/a	n/a	$92.52
Total		$878	$249.08	n/a	n/a	$249.08

Figure 1. Cost comparison: level 4 established-patient visit in an HOPD vs a private retina practice. Professional Medicare Allowable Data accessed on February 24, 2025: www.cms.gov/medicare/physician-fee-schedule/search.
Abbreviations: HOPD, hospital-based outpatient department; SD-OCT, spectral-domain optical coherence tomography.

substantial co-pays and deductibles. This financial burden can be especially challenging for older patients, who are more likely to suffer from retinal conditions and may be on fixed incomes.

Figure 1 compares costs for a typical follow-up visit in an HOPD vs at a private retina practice for an established complex retinal patient requiring bilateral imaging, including ultrasound.

Higher costs in hospital-based settings can also have an impact on access to care. Patients may delay or forgo necessary treatments because of financial constraints, potentially leading to worse health outcomes. This is particularly concerning for retinal diseases, where timely intervention is critical to prevent vision loss.

From the provider's perspective, HOPDs benefit from the additional revenue generated by facility fees. This can help hospitals maintain comprehensive services and subsidize care for uninsured or underinsured patients. However, this model also incurs higher charges, contributing to the overall increase in healthcare costs.

Private practice retina specialists face the challenge of competing with HOPDs, which can leverage their larger infrastructure and resources. Recently, private-equity acquisitions, along with hospital-acquired private practices, have attempted to extend hospital-based care into traditional private practice environments. Ultimately, private practices may offer more personalized care, which can be appealing to patients seeking a more tailored healthcare experience.

The higher costs associated with hospital-based outpatient care contribute significantly to the increase in US healthcare spending. Facility fees are a significant factor in the rising cost of care, which affects insurance premiums, government healthcare expenditures, and patients' out-of-pocket costs.

This discrepancy in outpatient charges has caught the attention of policymakers; there have been calls for greater transparency in healthcare pricing and efforts to regulate facility fees. For instance, some states have implemented laws requiring hospitals to disclose facility fees up-front, while federal initiatives aim to promote price transparency and competition.

IVT injections, a common treatment for age-related macular degeneration (AMD), illustrate this cost disparity between hospital-based settings and private practice settings. In an HOPD, the total cost for an injection, including the drug, physician fee, and facility fee, can be significantly higher than in a private practice, where only the drug and physician fee are billed.

Having practiced in both settings—academic hospital-based care at the Bascom Palmer Eye Institute (under the Anne Bates Leach Eye Hospital) and subspecialty office-based private practice (Miami Ocular Oncology and Retina)—I have a first-hand appreciation of the differential impact on both patient care and service cost. From my perspective, office-based care is undervalued, while hospital-based care is overvalued.

The cost breakdown in Figure 1 might look like this for a single patient receiving identical care in an HOPD or a private practice office setting:

The physician fee component for HOPD-delivered care is slightly less ($169.16 vs $249.08), but the hospital-based facility fee dwarfs the physician component, increasing charges by more than $4000. For patients receiving repetitive care, such as monthly injections, this cost difference can amount to tens of thousands of dollars annually.

The cost differential between sites of service is not unique to retina specialty care, or even ophthalmology at large. Several approaches have been proposed by policy researchers to address this issue across medicine, including:

- **Regulating facility fees.** Implementing caps on facility fees or requiring justification for high charges could help control costs.
- **Providing price transparency.** Mandating that hospitals provide clear, up-front pricing information can empower patients to make informed decisions about their care.
- **Encouraging competition.** Supporting the growth of private practices and outpatient clinics can foster competition and drive down costs.

Insurance companies can play a role in mitigating the impact of facility fees by:

- **Adjusting reimbursement rates.** Insurers could reduce reimbursement rates for hospital-based outpatient services to encourage that care be provided in less-expensive settings when appropriate.
- **Offering patient education.** Providing resources and tools to help patients understand their options and the cost implications of different settings can promote more cost-effective choices.

Healthcare providers, including hospitals and private practices, can also contribute to addressing the cost disparity by:

- **Striving for operational efficiency.** Hospitals can seek ways to reduce overhead costs and improve operational efficiency to justify lower facility fees.
- **Advocating for collaborative care models.** Encouraging collaboration between hospitals and private practices can ensure continuity of care while minimizing costs.

A major policy push has addressed the concept of *site neutrality* for Medicare payments as a major reform initiative. In this legislative framework, bipartisan support by Senators Bill Cassidy, MD (R-Louisiana) and Maggie Hassan, JD (D-New Hampshire) focuses on payments based on *care provided*, not on the site of care. The major opposition comes from one of the largest and best-funded lobbying groups, that of the American Hospital Association. As often happens, politics may "trump" policy.

The discrepancy in outpatient charges between hospital-based and private practice settings, driven largely by facility fees, has significant implications for patients, providers, and the healthcare system. Addressing this issue requires a multifaceted approach, including policy interventions, insurance reforms, and efforts by healthcare providers to improve efficiency and transparency.

By tackling the cost disparity, we can work toward a more equitable and sustainable healthcare system that prioritizes patient access and affordability without compromising quality of care. That facility fees profit the hospital—but are often ascribed to the physician—leads to a basic misunderstanding of true care costs and disadvantages the physicians providing care.

In This Issue

This issue leads with the ASRS Sustainability Committee's update on the Clinical Practice Guideline focusing on IVT injections. The Committee, noting worldwide numbers of IVT injections at 15 million, focuses on the need for collaboration between retina specialists, our industry partners, and our payer/stakeholders to reduce waste and foster sustainable environmental stewardship.[1]

El-Ali et al[2] present a meta-analysis comparing postoperative outcomes for visual acuity (VA) and refractive error. Of 3632 identified studies, exclusion criteria identified only 7 studies that were included in the analysis. Only 3 papers reported best-corrected visual acuity (BCVA) outcomes, and no statistically significant difference in outcomes was noted.

From a refractive perspective, combined surgery led to a −0.41 D myopic shift from the predicted refraction, while the standalone control group was +0.09 D. This study characterizes the issues with meta-analysis but supports the thought that combined phacovitrectomy can lead to excellent visual outcomes with refractive outcomes within 0.50 D of the predicted refraction.

Kannan et al[3] describe short-term perfluorocarbon liquid (PFCL) endotamponade for retinal detachments (RDs) related to giant retinal tears compared with pars plana vitrectomy (PPV) with silicone oil (SO) tamponade. PFCL endotamponade achieved an 82.7% anatomic success, while PPV/SO achieved 72.7%. The PFCL procedure used PPV with PFCL, leaving a 60% PFCL fill and a 40% 1000 cs SO bubble.

The patients maintained a supine position for 5 days and then had a second surgical procedure with ultimate exchange to a complete 1000 cs SO fill; the SO was then removed after month 3. The authors conclude that this short-term PFCL tamponade technique may enable improved anatomic and functional outcomes in these challenging RD cases.

Citirik et al[4] report Turkey's experience with short-term PFCL tamponade in the setting of RD with inferiorly located proliferative vitreoretinopathy. In this study, PFCL was left in place for 2 weeks with planned secondary PPV for removal with tamponade at the surgeon's discretion. Although recurrent RD occurred in only 6.2% of this cohort, inflammation was present in 14.5%. The authors suggest that this technique is a viable procedure for these challenging vitreoretinal cases.

Heier et al[5] present the clinical use of home OCT in managing neovascular AMD (nAMD). The authors noted that home OCT–based care for nAMD differed significantly from planned HOPD-based or office-based care. The authors suggest that home-based OCT may alter care from current in-clinic OCT evaluation.

Interestingly, for a single data segment reviewed by all 15 retina specialists, 9 of 15 (60%) elected not to treat during the data period, while 6 recommended treatment. This discrepancy highlights the variability in clinical care for IVT injection—our most common procedure.

Szigiato et al[6] highlight the utility of OCT-based analysis using subretinal pigment epithelium illumination area analysis to recognize geographic atrophy (GA). Their study suggests that 7.1% of eyes with intermediate AMD had GA that was not reported. In the 129 eyes, false positives were present for 50 eyes (38.8%) for which the grading team noted no GA. Standardized interpretation focused on high sensitivity and specificity will be a key to an automated approach to imaging.

Khan et al[7] use machine learning to quantify fluid in eyes with retinal vein occlusion (RVO) treated with aflibercept and found that intraretinal fluid volume, intraocular pressure (IOP), and retinal nerve fiber layer thickness, along with ischemic indices, correlated with BCVA.

The study was limited by the number of patients included along with difficulties in OCTA imaging in eyes with RVO. The authors suggest that a larger cohort and studies at more frequent timepoints could further improve our ability to predict best visual outcomes at a patient level.

Sheth et al[8] perform a retrospective review of open-globe injuries with subsequent associated RD. The best correlation to better visual outcomes was a time to initial vitrectomy of less than 21 days. In the 6-year study window, 214 open-globe injuries were noted; enucleation was performed in 22 eyes, with 68 eyes having an associated RD. Of these eyes, 36 had an RD noted within 14 days and had a 6-month follow-up. The authors suggest that earlier retinal referral and evaluation may improve both anatomic and visual outcomes for these often-catastrophic injuries.

González et al[9] report the Miami experience with multimodality treatment for complex Coats disease and highlight the elimination of the need for enucleation. Multimodality treatment began with IVT antivascular endothelial growth factor (anti-VEGF) treatment combined with targeted transpupillary laser therapy. As-needed posterior sub-Tenon triamcinolone acetonide was used, and all 68 patients had total resolution of the RD.

The authors focus on the benefit of widefield imaging, targeted laser ablation of microaneurysmal vascular changes, and repetitive anti-VEGF as critical to the outcome, leading to 26% of eyes achieving a VA of 20/40 or better, 39% achieving 20/50 to 20/400, and the remaining 19% achieving 5/200 or better.

Lane et al[10] evaluate fine-needle aspiration biopsy for uveal melanoma using both cytopathology and gene expression profiling. In the 141 patients, gene expression profiling remained clearly predictive of metastatic disease progression, with class 1a at 10.5%, class 1b at 15.0% and class 2 at 45.0%. This suggests the importance of gene expression profiling and the differential risk between class 1a and class 1b.

The authors conclude that cytopathology had neither a negative nor a positive outcome impact on patients who had gene expression profiling analysis. These data support the accuracy of clinical diagnosis of uveal melanoma and the ability of gene expression profiling to predict metastatic future disease.

Subramanian et al[11] describe the clinical presentation of primary and secondary vasoproliferative tumors. Secondary vasoproliferative tumors were typically unilateral and unifocal. For secondary vasoproliferative tumors, the etiology was Coats disease, then intermediate uveitis, then familial exudative vitreoretinopthy, and then trauma. The authors stress the importance of multiple treatment sessions and intensive follow-up to achieve anatomic stability.

Rana et al[12] evaluate the impact of IVT anti-VEGF injections on elevated IOP. Typically, IOP elevation occurred after 5 to 6 injections and was seen in approximately 6% of injected eyes. These data document the need for clinical evaluation of patients undergoing anti-VEGF therapy to include IOP assessment. The mechanism of IOP elevation remains unclear, as does the value of paracentesis at the time of IVT injection. Nonetheless, with 15.1 million injections worldwide, these patients deserve comprehensive assessment and follow-up.

Chalasani et al[13] model the prediction of vision loss after lapsed anti-VEGF therapy for patients with diabetic macular edema. Similar negative impacts on anatomic and visual outcomes were seen during the COVID-19 pandemic, where delays in treatment were associated with visual and anatomic compromise. This study supports the critical nature of ongoing care, in particular for our highest risk patients, and highlights the need to improve educational and clinical support for these patients to maintain vision.

Parolini et al[14] present our first case report of combined repair of macular hole (MH), tractional RD (TRD), and high myopia treated with macular scleral buckling, PPV, and subretinal bleb elevation followed by sulfur hexafluoride tamponade. Both patients achieved MH closure, with one patient recovering 20/50 BCVA. These complex patients continue to push our surgical approaches to anatomically close the MH while improving VA.

Habib and Boss[15] report a case of secondary lymphoproliferative disease induced by mycophenolate mofetil treatment of posterior uveitis in a 34-year-old Hispanic woman. The authors focus on the need for high suspicion for atypical uveitis and the importance of diagnostic vitrectomy to characterize primary or secondary lymphoma.

Systemic rituximab, high-dose methotrexate, and IVT methotrexate stabilized the VA and anatomy with a BCVA of 20/100 OD and 20/30 OS. The authors discuss the impact of treatment on the potential for untoward treatment-related events. Again, patient education and targeted follow-up are critical for all aspects of our retina specialty treatments, in particular when the treatment-induced complication may be worse than the disease.

Duke et al[16] present a 30-year-old Asian woman with secondary choroidal neovascularization (CNV) within focal choroidal excavation and highlight the benefit of OCTA for both diagnostic evaluation and as a monitoring image for treatment response and retreatment indications. Remarkable response to IVT bevacizumab was documented, and the VA improved to 20/20. Previous studies have noted CNV in 7% to 16% of patients with choroidal excavation.

Shah et al[17] present a 24-year-old woman with a history of consanguinity who presented with a Coats-like response secondary to Poretti-Boltshauser syndrome. Mutations in *LAMA1* encoding for extracellular matrix proteins leads to a progressive cerebellar syndrome. Once again, the importance of recognizing the primary cause of a secondary Coats-like response is emphasized.

Yuan et al[18] report a 40-year-old insulin-dependent patient with diabetes, hypertension, chronic obstructive pulmonary disease, and congenital heart disease. This patient's medical health prevented surgical intervention, leading to repetitive IVT anti-VEG injections with bilateral macula-involving TRD.

The authors acknowledge the concern with possible "crunch" syndrome but fortunately this patient, treated with repetitive IVT bevacizumab and secondary panretinal photocoagulation, experienced resolution of the TRD and anatomic and visual improvement.

Turski et al[19] present our second patient with lymphoma. This 54-year-old White man was treated over 11 months for bilateral RVO, central RVO in the right eye, and hemi-RVO in the left eye. At 11 months, the patient had blood testing with a complete blood cell count and differential, which suggested a lymphoproliferative process. A bone marrow biopsy confirmed a stage 4 mantle cell lymphoma.

This patient had observational therapy, holding the previous IVT anti-VEGF treatment. At 3 months, he developed a vitreous hemorrhage in the setting of RVO. Both vitreous hemorrhages and neovascular glaucoma benefit from anti-VEGF treatment, reiterating the importance of ongoing ophthalmic evaluation.

Seddigh et al[20] expand our understanding of the potential impact of COVID-19, as well as potential concerns for vaccine therapy, in a 28-year-old man who presented with serpiginous choroiditis 1 month after a documented COVID-19 infection. The authors discuss possible mechanisms for potential causality as well as this patient's lack of response to high-dose oral steroid and oral azathioprine.

Castro et al[21] present an 8-year-old White male child with CNV formation secondary to multifocal torpedo maculopathy. IVT anti-VEGF therapy led to involution with remarkable visual recovery to 20/20.

Kim et al[22] report a 38-year-old Black man with bilateral visual compromise in the setting of type 2 diabetes, hypertension, and obesity along with chronic methamphetamine use. The patient was treated with IVT anti-VEGF injections and was scheduled for surgery.

Uneventful vitrectomy with membrane peeling was performed in the left eye, after which the patient presented with evolving stroke syndrome. Multiple workups confirmed Moyamoya disease, and the patient was discharged. The patient had outpatient neurosurgery but was then lost to follow-up. This case again exemplifies the complexity of our real-world patients, who often present with multiple comorbidities.

Iftikhar et al[23] revisit surgical management of submacular hemorrhage in a 79-year-old man with enlarging pigment epithelial detachment (PED) in his better-functioning right eye with known nAMD in the left eye. Two weeks after this evaluation, the patient reported severe vision loss in the right eye and was noted to have experienced a submacular hemorrhage. The patient received IVT faricimab and had vitrectomy displacement of the hemorrhage.

Postoperatively, the patient was treated with anti-VEGF every other week. The VA recovered to 20/70 at 5 months. The authors comment on the decision *not* to treat the PED, recognize the limitations of surgical management, and comment on the need to follow surgical treatment with anti-VEGF.

Desai et al[24] present a unique presentation of frosted branch angiitis after scleral buckling in a 39-year-old man. On postoperative day 5, retinal exudation and an intraretinal hemorrhage clinically consistent with frosted branch angiitis were noted. Oral ciprofloxacin was instituted, followed by progressive involvement over 24 hours and initiation of oral prednisone.

One week later, progressive RD was noted and the patient was taken to the operating room for a vitrectomy, endolaser application, and SO tamponade. Vitreous biopsies were negative for bacterial, fungal, or viral involvement. Two months later, the SO was removed and at 4 months, the VA had recovered to 20/30 with full resolution of the angiitis.

Olis et al[25] report a 64-year-old woman presenting with bilateral diffuse uveal melanocytic proliferation in the setting of high-grade stage IIIC ovarian clear cell adenocarcinoma. Aggressive treatment with plasmapheresis was instituted, and sub-Tenon steroid was given in the setting of the exudative RD.

Bilateral diffuse uveal melanocytic proliferation treatment was held when the patient noted deterioration of function, and the patient was lost to follow-up. The report includes an excellent discussion of bilateral diffuse uveal melanocytic proliferation, including current hypotheses and potential treatments.

Our concluding case by Winebrake et al[26] focuses on a 52-year-old man with chronic posterior syphilitic uveitis. The long-standing, low-grade uveitis initiated a unique finding of outer cystic retinal alterations with macular CNV formation. The patient was admitted, and penicillin treatment was initiated.

The patient then received IVT ranibizumab twice, followed by ongoing monthly IVT bevacizumab. "Comet" lesions, first reported in 2003, were then discussed along with outer retinal tubulations. Fortunately, the VA stabilized at 20/25 OD and $20/30^{+}$ OS. The authors suggest ongoing evaluation and targeted anti-VEGF as needed, along with counseling for safe-sex practices.

These cases display the intensive and critical nature of retina specialty care that often goes far beyond care of the eye itself. Ultimately, our goal should be to ensure that patients receive the care they need at an affordable price, regardless of where they seek treatment. For retina specialists and their patients, achieving this balance is crucial in the fight against vision-threatening diseases and in promoting overall eye health.

As advocated by suffragette Carrie Ashton Johnson (1863–1949) and enacted into law by President John F. Kennedy in 1963, "Equal pay for equal work." This discussion reminds us that the issue of equal pay goes far beyond gender and impacts today's US-based healthcare daily.

My first disclaimer: This editorial, like all my columns, is independent of the ASRS and reflects my opinions (which may differ significantly from those of the Society). I applaud the ASRS' focus on its active role in supporting patient care—both directly and indirectly—in advocating for our patients, our specialty, and our retina specialists.

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References

1. Grodsky JD, Schehlein EM, Chang DF, et al. So many injections, so much waste: understanding the environmental impact of intravitreal injections. *J Vitreoretin Dis*. 2025;9(2):131-134.
2. El-Ali O, Koklanis K, Vukicevic M, Heriot WJ. Postoperative outcomes of combined phacovitrectomy for epiretinal membrane with a concurrent cataract vs standalone phacoemulsification for a cataract. *J Vitreoretin Dis*. 2025;9(2):135-143.
3. Kannan NB, Vallinayagam M, Balakrishnan T, Sarkar AD, Rajan RP, Ramasamy K. Short-term endotamponade with perfluorocarbon liquids for giant retinal tear–associated retinal detachment. *J Vitreoretin Dis*. 2025;9(2):144-150.
4. Citirik M, Ilhan C, Horozoglu Ceran T, Teke MY. Vitrectomy with short-term perfluorocarbon liquid tamponade for retinal detachment with inferior retinal breaks and proliferative vitreoretinopathy. *J Vitreoretin Dis*. 2025;9(2):151-157.
5. Heier JS, Liu Y, Holekamp NM, et al. Clinical use of home OCT data to manage neovascular age-related macular degeneration. *J Vitreoretin Dis*. 2025;9(2):158-165.
6. Szigiato A, Maatouk CM, Azar AE, et al. Detection of geographic atrophy guided by optical coherence tomography sub-RPE illumination analysis in patients with intermediate age-related macular degeneration. *J Vitreoretin Dis*. 2025;9(2):166-173.
7. Khan MA, Sodhi SK, Orr S, et al. Machine learning quantification of fluid volume in eyes with retinal vein occlusion treated with aflibercept: the REVOLT study. *J Vitreoretin Dis*. 2025;9(2): 174-179.
8. Sheth N, Chang AY, Bryan JM, Massengill MT, Lim JI. Outcomes of open-globe injuries with associated retinal detachment: experience at an ocular trauma center. *J Vitreoretin Dis*. 2025;9(2):180-186.
9. González NC, Villegas VM, Berrocal AM, Gold AS, Latiff A, Murray TG. Targeted multimodality treatment to eliminate the need for enucleation in advanced Coats disease. *J Vitreoretin Dis*. 2025;9(2):187-191.
10. Lane AM, Hartley CD, McCarthy R, et al. Confirmatory cytopathology and potential impact on the predictive value of gene expression profiling in patients with uveal melanoma. *J Vitreoretin Dis*. 2025;9(2):192-197.
11. Subramanian B, Nangia P, Rishi P, et al. Clinical profiles of retinal vasoproliferative tumors. *J Vitreoretin Dis*. 2025;9(2):198-203.
12. Rana NA, Chalasani M, Markle J, et al. Evaluation of sustained intraocular pressure elevations across antivascular endothelial growth factor agents. *J Vitreoretin Dis*. 2025;9(2):204-211.
13. Chalasani M, Maatouk C, Markle J, Singh RP, Talcott KE. Predictors of vision loss after lapse in antivascular endothelial growth factor treatment in patients with diabetic macular edema. *J Vitreoretin Dis*. 2025;9(2):212-218.
14. Parolini B, Matello V, Rosales-Padrón JF. Combined surgical approach for repair of refractory macular hole in myopic traction maculopathy. *J Vitreoretin Dis*. 2025;9(2):219-223.
15. Habib NB, Boss J. Mycophenolate mofetil–induced lymphoproliferative disorder in a young adult with chronic posterior uveitis. *J Vitreoretin Dis*. 2025;9(2):224-227.
16. Duke RCT, Anshumali S, Crosson JN. Optical coherence tomography angiography in macular neovascularization secondary to focal choroidal excavation. *J Vitreoretin Dis*. 2025;9(2):228-231.
17. Shah S, da Cruz NFS, Lopez-Font F, Staropoli P, Berrocal A. Exudative vitreoretinopathy with a Coats-like response in Poretti-Boltshauser syndrome. *J Vitreoretin Dis*. 2025;9(2):232-235.
18. Yuan M, Hoyek S, Kim LA, Chaaya C, Patel N. Antivascular endothelial growth factor injections for the chronic treatment of macula-off, fovea-on diabetic tractional retinal detachment with vitreous hemorrhage. *J Vitreoretin Dis*. 2025;9(2):236-240.
19. Turski CA, Kirimli GU, Vajzovic L, Scott S, Hadziahmetovic M. Ischemic retinopathy associated with mantle cell lymphoma–induced vascular occlusion. *J Vitreoretin Dis*. 2025;9(2):241-245.
20. Seddigh S, Pinto A, Zaki AM, Gupta RR. Serpiginous choroiditis after COVID-19 infection. *J Vitreoretin Dis*. 2025;9(2):246-252.
21. Castro MC, Liu T, Capone A, Drenser KA, Trese MGJ. Multifocal torpedo maculopathy complicated by choroidal neovascularization. *J Vitreoretin Dis*. 2025;9(2):253-256.
22. Kim AJ, Sabbagh O, Sabbagh O, Abou-Jaoude M, Kitchens JW. Tractional retinal detachment in a patient with a history of methamphetamine use. *J Vitreoretin Dis*. 2025;9(2):257-261.
23. Iftikhar M, Hsu ST, Vajzovic L, Hadziahmetovic M. Acute submacular hemorrhage resulting from neovascular age-related macular degeneration in a monocular patient. *J Vitreoretin Dis*. 2025;9(2):262-265.
24. Desai A, Tyagi M, Narula R. Frosted branch angiitis–like retinal vasculitis developing after scleral buckle surgery. *J Vitreoretin Dis*. 2025;9(2):266-269.
25. Olis M, Weppelmann TA, Patel M. Bilateral diffuse uveal melanocytic proliferation in the setting of ovarian cancer. *J Vitreoretin Dis*. 2025;9(2):270-274.
26. Winebrake JP, Chirko D, Papakostas T, Kovacs KD. Multimodal imaging of a unique transitory finding in ocular syphilis. *J Vitreoretin Dis*. 2025;9(2):275-279.