

**About Health TV with Jeanne Blake**  
**Eye Care**  
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JEANNE BLAKE: Welcome to *About Health TV*. I'm Jeanne Blake. Our eyes – we need them, and unfortunately too often take them for granted. Until, of course, something happens that can threaten our vision. On this edition of *About Health TV*, we're going to talk with two experts about how we can take care of our eyes and preserve our vision, and what to do, by the way, when something goes wrong. Joining us for this discussion of our eyes are two experts, Dr. Brad Shingleton, who is an assistant professor at Harvard Medical School and a surgeon at Massachusetts Eye and Ear Infirmary, and Dr. Susan Bayliss, who is an optometrist who practices with Dr. Shingleton at Ophthalmic Consultants of Boston. There, how's that for a long lead-in. Thanks so much for coming in to talk about one of my favorite subjects. What I'd like to start with – we have a model of the eye here. I think a lot of people don't understand how our eyes work. Can one of you demonstrate the eyeball for us.

DR. SHINGLETON: That is important. The first thing to appreciate is, an analogy of an eye to a camera. And it sounds simple, but it really is a great analogy. We've got a front of the eye and we have a back of the eye, just like a camera, there's a lens in the front and film in the back. Just as in the camera, the eye has a clear window that we look through, which is the cornea. It then has a focusing element called the lens, and it focuses the light back on the back part of the eye, which is called the retina. The cornea and the lens is the camera lens focusing element, and the retina is just like the film in the camera. We need to process that light and have it focused in a sharp axis right at the back of the eye. So that, simply stated, is just how the eye works.

JEANNE BLAKE: That's a good basis for the subjects we're going to talk about through the next half hour. The first one, I'm sitting here with my glasses in my hand. They're reading glasses. I've got great, thank goodness, still can see at great distances, with I believe 20/20 vision, but I have to have these to read, and over the last five years I've needed stronger and stronger glasses. What goes on, Dr. Shingleton, in the eyeball, when someone starts to need glasses to read with?

DR. SHINGLETON: It is, first of all, a normal process.

JEANNE BLAKE: I know that.

DR. SHINGLETON: It is critical to appreciate that. ... And it really goes back, again, to the anatomy, and I think I'll just keep this up. This lens of the eye, which is crystal clear like glass, becomes a little more rigid, a little more stiff, and doesn't quite have the ability to round up and change shape to focus that light in the retina. And actually, that's what Dr. Bayliss talks about so much. She is the one who really is responsible in our office for helping the people with the lens that goes in front to see a little bit better.

DR. BAYLISS: One of the things people, I think, don't understand is, as you mature you lose your ability to focus. It's not just bringing things further away to see, you also lose your range of focus, so that you can't just get one pair of glasses that's going to do everything up close. You may need a pair of glasses just for reading, maybe a separate power for the computer. Different visual needs. People who are piano players or violin players or computer users may need a different prescription for the computer compared to what they need to read.

JEANNE BLAKE: For example, if I have – and I will say that I use, with the doctor's permission, glasses that I buy at the drugstore. These are, I think these are 175s or 200s. So if I were going to be looking at the computer, which is this far away, as opposed to reading, which is this far away, am I going to need a stronger or –

DR. BAYLISS: A weaker prescription.

JEANNE BLAKE: Weaker, really?

DR. BAYLISS: The further away you're going to hold things, the weaker the prescription.

DR. SHINGLETON: When you think about it also, if you're going to look at a map, something real close with a magnifying lens, and it's a high-power lens, and it brings the focus up real close. It's the same thing. And then you want to be out here, you get a lower number.

JEANNE BLAKE: That makes sense. And what's going wrong when I can't see, eventually, probably, a sign driving down the highway and I need glasses for that? What's going on in the eyeball, Dr. Bayliss?

DR. BAYLISS: There are lots of different reasons why you lose your vision at distance. I would say if you looked at somebody like you, who has perfect distance vision, and as you mature your lens may

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harden to the point where it actually starts to get cloudy, and that's what we call development of a cataract. Sometimes you can get more nearsighted when that happens. Sometimes there's nothing we can do with prescription glasses to clear that up.

JEANNE BLAKE: We're going to talk about cataracts in just a minute, but hundreds of thousands, or millions of Americans wear glasses to see distance, and they're not all walking around with the early stages of a cataract.

DR. BAYLISS: That's correct. That's basically the shape of the eye. In that case, what's happening is, the lens and the cornea here are focusing all the rays of light in front of the retina, and what you need is the correct lens to bring the focus back to the retina.

DR. SHINGLETON: That's a good way to think about it. When you're nearsighted, you have a little trouble seeing far away, you can see up close. The eye is actually longer than it should be, and the light focuses in front of the film of the camera. You put a lens to move that focusing back. If you're farsighted, which is just the opposite, you usually can see well far away but can't do as well up close. Actually, the focus is way back here, and we need to bring a stronger lens to focus it onto the retina. So it's just one side or the other.

JEANNE BLAKE: But the shape of the eye, can it change as you grow older?

DR. SINGLETON: No, but we're all a little bit farsighted, we're a little bit nearsighted, and as we get into our 40s and 50s and 60s, that farsightedness finally catches up to us.

JEANNE BLAKE: We're going to talk about cataracts, glaucoma, and the things that can go wrong, the diseases. But I want to start in a more positive vein. I'm wondering what we can do. What can we do in our day-to-day life to preserve our eyesight? What are some of the main ways that we can help ourselves that way?

DR. SINGLETON: The first thing that's important to appreciate is that the eyes are really remarkably resilient, you can use your eyes and don't feel like you can overuse them in terms of reading or taxing them too hard with close work. Computer work does not seem to make any problem with healthy eyes. There are, however, certain things you want to be sure to do, and that is, first and foremost, if one is active outdoors in sports, if one plays racquet sports or things like that, eye prevention in terms of protective eyewear is a critical factor. You really can prevent eye problems. But in terms of general

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activities, it's really important to appreciate that you can be using your eyes pretty much 24 hours a day, seven days a week, and not have a problem, assuming, again, you're aware of problems that develop and get your eyes checked regularly.

DR. BAYLISS: The only other thing I would mention is that people – although we can use our eyes without hurting or damaging tissue, your eyes can get tired if you're doing a lot of near work or computer work. I think the easiest thing to do to keep your eyes from fatiguing is to take breaks every 15 minutes or so, look away from the computer, away from the near work, out a window. And there are lots of little tips in terms of visual hygiene, where you're going to have your computer set up so that, if you have a window, you don't want the window in front of the computer or behind the computer so you get glare. Little things like that. All the things all mothers told us about proper light.

JEANNE BLAKE: But that's day-to-day comfort.

DR. BAYLISS: That's day-to-day comfort. Again, it's not anything about hurting the eye or losing your vision, it's just comfort.

JEANNE BLAKE: I had someone say to me just a couple of weeks ago, "You better turn the light on, you're going to go blind, you're going to ruin your eyesight." I said that's a myth. I said I asked my doctor about that, and that was a myth. But that's one of the things we grow up with and hear about.

DR. SHINGLETON: We also mentioned briefly about getting your eyes checked, and we should talk a little bit about that. When should you have your eyes checked? First and foremost is when there's a problem: blurred vision, double vision, pain, redness, that type of thing, you want to get your eyes checked. But assuming you don't have that, you have healthy eyes, you're doing well, I think children at the preschool age – that is, when they enter school – should have the basic screening vision exam. That's an important time. Sometime in the early 20s, just as a good baseline to make sure the pressure is fine. The critical period then becomes in the 40s, when reading becomes a little bit of an issue, and that's when, also, the issues, if they are to develop, may manifest, such as cataracts, glaucoma, other problems. So early 40s is when we probably have a checkup every few years, into the 60s, every year or two.

JEANNE BLAKE: I have a family history of macular degeneration. We'll explain what that is in a minute. I have my eyes checked every year. Is that too often? Am I being too careful?

DR. SHINGLETON: Not at all too often. The critical thing is that family history issue, and that's another thing, in terms of symptoms and the family history, or anything else that might predispose you to a problem ... If everything checks out very well, and the eyes are very good, it may be appropriate to have a checkup every year or two. But in the ball park of a year to every three years, if there's a family history of a specific problem, are what needs to be done.

JEANNE BLAKE: Before we go into the specifics, what about diet? I had a friend say, "Please ask the doctors about whether we – do carrots really make you see better?" Are there myths? And are there things that we could be doing, vitamins or foods we could be eating, that can be beneficial?

DR. BAYLISS: There's a lot of theories out there, but I would say, especially with things like macular degeneration, leafy greens, a diet full of leafy greens, and antioxidants like selenium, zinc, copper. Those things on a daily basis, taking those types of supplements on a daily basis are thought to help.

JEANNE BLAKE: Really? Have there been controlled studies?

DR. SHINGLETON: That's the big problem. It's so difficult to objectively analyze. We need so many patients, you need to compare a person taking medicine and not taking medicine. But subjectively there's some theoretical evidence to suggest that the antioxidants – you mentioned a couple, like selenium, vitamins A and E, C – may stabilize the retina in people with a tendency towards macular degeneration. That's probably the most subjective evidence we have, and it happens to be very much the type of compounds that are prevalent in green leafy vegetables, spinach, that type of thing. So that may help some people. Whether there's some other vitamins that might help glaucoma or cataract formation, things like that, it's all speculation.

JEANNE BLAKE: Of course you know my question, the obvious question, why would an antioxidant help in macular degeneration?

DR. SHINGLETON: This is where we really get into the basic science. There literally is – if you can picture, I showed a picture of the retina here in a model. This retina is an extraordinarily complex layering, multi-layering –

JEANNE BLAKE: Normally we don't do this, because I don't want it to look like – you are the professor at Harvard, we don't want to make this look like an academic class, but I'm so fascinated, look at this wonderful machine that helps us see.

DR. SHINGLETON: Once again, just to orient us again a little bit. The front of the eye, the clear window that we look through called the cornea. The lens, which should be clear, and we'll talk about cataracts a little bit later, because that's what happens when it gets cloudy, it's called a cataract. But the light gets focused on the retina, this is where the blood circulation actually comes into the eye. And here's a blowup of this retina and the optic nerve. But the retina itself, you can see schematized here in different colors, is actually a lamellar structure of lots of layers. And it turns out, at the base of that retina there's really a photochemical reaction, where these antioxidants, which we talked briefly about, may actually stabilize what's called the free radical interaction with these chemicals, and that may, theoretically, again, help prevent some of the progression from macular degeneration.

JEANNE BLAKE: I know how awful a disease it is. My mother lives with it. So I think I'm crazy to not try it. If it's a preventative measure that I can take, why not try it?

DR. SHINGLETON: The other thing is, as best we can tell, the risks don't seem to be anything to speak of, so the benefit may be there.

JEANNE BLAKE: Exactly. Can you talk, please, about what macular degeneration is? I was going to save that till the last, but we're talking about it right now. For folks that don't know, what is going on in the eye?

DR. SHINGLETON: The macula, which is part of the retina, at the back part of the eye – let's go to this again. It's the center part of the retina that we use for our good vision. The retina serves a function for the peripheral vision, but the macula is the part for the reading vision, the vision that we look at when we look at TV. And for whatever reason, again, mostly because we don't know, probably related to circulation and probably related to that outer layer that I mentioned, there's actually some irregularity that develops, some scarring that develops right in the center of this macula. And that is the part that gives us the good function, and very slowly that can affect the ability to focus clearly and precisely. One never, or very rarely, loses the ability to walk around and see and negotiate and take care of yourself at home. But the ability to read a newspaper, the ability to drive, critical issues of self-care become problematic.

JEANNE BLAKE: My mother is in a nursing home, because she really cannot take care of herself, and she has a number of health issues. She's also in Minnesota, so I send her faxes that she now – she also can't hear. Talking on the telephone is an exercise in frustration. But sometimes we'll get on the phone, even if she can't hear, just to have the human contact. But she loves faxes. About a month ago, she said, "Can you give them in bigger letters?" So now the fonts are really, honestly, about this

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big, and she's got a high-intensity light that's provided by some association for the blind, which is a wonderful organization, and between the big font and this high-intensity light and this thing that she puts over it, she's able to read these faxes.

DR. SHINGLETON: Dr. Bayliss does a lot of work in helping people ...

DR. BAYLISS: We do a lot with magnifiers and very strong reading glasses, and there are also other things available, like CCTV, closed circuit television, where you can actually take a book and put it in this machine, and it enormously magnifies it so that people can actually read. There are all kinds of little tricks we can do that make people more functional in their day-to-day activities, including writing checks. I wouldn't say occupational therapy, but there are occupational things, or physical things we can do just to kind of train people to use their eyes even though they have that impaired vision.

JEANNE BLAKE: There are some magazines – my mother reads Time magazine in large print, which I'm really grateful for.

DR. BAYLISS: And Reader's Digest. One thing I don't know about, I've seen, is this new e-book. I don't know enough about it, but I have to look into whether or not they can actually enlarge the print in this little book, that you can actually download a book off the Internet and read.

JEANNE BLAKE: Great. You're starting to really be able to help people who are living with limited vision.

DR. SHINGLETON: I do want to say one other thing, though. Macular degeneration is a common problem, and it is important to appreciate that of those who have macular degeneration, really only 10 percent or so tend to have it to the point where it is incapacitating, or really a problem in terms of their daily lifestyle. It is not uncommon to have some of the early changes, and to have it be stable for many years.

JEANNE BLAKE: But it's a progressive disease, is it not?

DR. SHINGLETON: It is, but it's progressive in a certain percentage, and relatively speaking it's a small percentage. If one has these changes, early precursor type changes, it does not in any way mean that the person's vision will be poor. It just means they need to be watched closely and followed by a person who's very comfortable examining this type of thing.

JEANNE BLAKE: That's important, to offer that reassurance to people.

DR. SHINGLETON: Absolutely.

DR. BAYLISS: I had a patient who had advanced macular degeneration who, after I worked with her with magnifiers, giving her her best vision, all these special instruments that we were talking about, at the end of this whole thing, when I got her to read a book, she said, "Doctor, I have a really important to question to ask you." I said, "What?" She said, "Am I going blind?" And I got such a kick out of it, because here I was with low-vision aids with this patient, a patient with advanced macular degeneration, and she didn't have a concept of herself, she didn't perceive herself as being blind ...

JEANNE BLAKE: I, of course, have paid close attention to the research, and there is a laser surgery that's now being done in the early stages of macular degeneration. Do you do the surgery?

DR. SHINGLETON: Actually, in our group – we're fortunate in our group, Ophthalmic Consultants of Boston, we have a team and we subspecialize. We have a team of my colleagues who specialize just in the retina. There are actually a series of programs being done, and we're active investigators in laser treatment for macular degeneration. There are also some other photodynamic, other therapies. There's a host of things being done. This is critical for people to get plugged in to systems and allow them to have access to what's clearly, I would say, if I were to single out the area that's receiving as much attention as anything on the basic science and clinical research arm, it's macular degeneration.

JEANNE BLAKE: Can you explain how that would work, what the laser does inside the eye?

DR. SHINGLETON: A lot of the problem with macular degeneration is a circulation problem, and some abnormality in the vessels in that layer right at the base below the retina. Sometimes we can eliminate the abnormal vessels and prevent progression and scarring in the central zone, which is the critical area of focus. That's a very general way to do it. And then this other photodynamic here, you can actually stimulate and improve the function.

JEANNE BLAKE: Let's move on to some of the other disease, I guess. Is a cataract a disease?

DR. SHINGLETON: That's a good question. First of all, it's not a growth or a tumor or anything like that. That's real important to appreciate. It's also not an appendix that's going to rupture, so people

don't have to have them taken out tomorrow. But it is, technically it's an abnormality, but it's a common thing that if we all live long enough we get it.

JEANNE BLAKE: So you really focus your practice, your particular practice within Ophthalmic Consultants of Boston, on cataracts and glaucoma. That's your particular specialty. And you're recognized nationally for the work that you've done. Dr. Shingleton, let's just describe, I guess using the eye model, this one, what a cataract is.

DR. SHINGLETON: This is so important. I want to just preface my remarks again by what it is not. It is not a growth. It's not a tumor. It's a normal change in the eye. This lens I talked about earlier, which is right behind the cornea, which is the focusing element of the eye, should be just a clear lens. It's about the size of a button on my shirt, in actual size. And it's crystal clear when we're born, and it focuses the light precisely on the retina. And all a cataract means is that lens, instead of being clear, it gets a little foggy. It's like looking through a frosted window, a window that's got some distortion, like putting an oil droplet on it, it causes scattering of the light. It affects reading, it affects driving. Depending on the location of the cataract, it can cause glare. These things can slowly get to the point where it really becomes more incapacitating in terms of function.

JEANNE BLAKE: Why does the lens become cloudy? I'm like a 2-year-old. Why, Daddy?

DR. SHINGLETON: It clearly is, there's a genetic predisposition without question. If you have a family history of cataracts, you have a higher chance of developing a cataract. Nutritionally, it is a factor. We see in third world countries, in particular, where diet is a problem, where cataracts develop much earlier. And then ultraviolet exposure, and we're probably talking about intense or chronic ultraviolet exposure, may be another predisposing factor. Fishermen ... see all the time, have a higher instance of developing cataracts.

JEANNE BLAKE: Surgery has changed dramatically. I remember my grandmother having – my grandmother came home with her cataract, this little ball in a jar. Now, why she wanted it, why they gave it to her, I don't know. But one of my memories of being a little girl is Grandma's –

DR. SHINGLETON: That is a good story – and Dr. Bayliss will follow up on this – because that's the way we used to take out cataracts, years ago. We used to make an incision this big with a needle about this big, and we used to take it out in one big ball, and out it came like this.

JEANNE BLAKE: And into the jar.

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DR. SHINGLETON: Into the jar. Fortunately – now remember, we’re taking out the cataract, we’re taking out the lens of the eye that focuses the light. In those days we didn’t have anything to put in. But Dr. Bayliss knows how we used to correct the lens.

DR. BAYLISS: We used to make these glasses that would magnify your eyes almost as much as an actual lens. It would actually take the place of the powerful lens, so you’d have this huge, thick magnifying lens. And what would happen is, they couldn’t make it for the whole frame, so you’d have a very small, very thick lens in the middle with what we would call a carrier lens on the outside. It was very difficult to see, and it would magnify everything, and it was definitely a struggle.

DR. SHINGLETON: ... glasses we used to have. But technologically now, the changes have been dramatic in the past two decades. I just feel so fortunate to be able to do what I do, because we help people so much. I mentioned that big incision used to be made all the way over the top of the eye. We now make, it’s several millimeters in size, and we can go in with a special probe, it’s like a laser, it’s not exactly a laser ... we can dissolve this lens. Instead of taking it out in one big piece, we emulsify it into a solution, aspirate it from the eye, and then preserve it in the near little capsule that surrounds it, to allow us to put a new lens, a new clear lens, into the eye in exactly the same position. So it obviates the problems that you have before of the big, thick lens in front of the eye that looked like a Coke bottle, and we have a normal lens that goes inside the eye. We actually can fold the lens up through that little tiny excision. And people, the next day, see remarkably well, and most importantly, their activity level the next day is remarkable normal.

JEANNE BLAKE: I did read on your website that they’re not allowed to wear mascara for a week, which of course –

DR. BAYLISS: You don’t want to get an infection.

DR. SHINGLETON: And no smoking for a couple of weeks. But basically, we let them do normal activities.

JEANNE BLAKE: When I hear of going inside the eye with ultrasound, it sounds so scary to me. The eye is such a fragile organ. But I know that with technology now, with a computer you limit where the ultrasound goes, and it’s really a very safe operation.

DR. SHINGLETON: Very safe, and totally comfortable. This is important to appreciate too. We're talking about a procedure that is absolutely painless. The procedure now, we're talking in the range of, oftentimes, 10 minutes to complete the procedure, and a recovery that – and again, it's a tribute to our technology – in the past we used to put needles behind the eye to numb the eye, and wear patches. We now oftentimes do the surgery with just anesthetic drops, so the person can literally see right after the operation. It is fantastic. Again, it's not for everyone. We should talk a little bit about who should have a cataract. It just sounds so good, why not have it done today? And it is the right thing for many people, but we base the decision for surgery on a person's function. If you're seeing pretty well and not compromised, you don't take the risk of surgery, albeit very small. But when it gets difficult to drive, difficult to read, these are things that are important in terms of your lifestyle, that's the time. I think people can now at least enter the procedure with much less fear and trepidation and be very comfortable.

JEANNE BLAKE: The other day I took my dog to the vet. She's a 15-year-old golden retriever/yellow Lab, she has cataracts. The doctor said, "I don't think we'll be doing anything about that. She can read just fine."

DR. SHINGLETON: In New England, there are several veterinary ophthalmologists ...

JEANNE BLAKE: Let's move on to glaucoma, because this is a silent, deadly – well, not deadly, but it's a silent –

DR. BAYLISS: Stealer of vision.

JEANNE BLAKE: Stealer of vision, thank you, Dr. Bayliss. To me it's so frightening because it's so silent. Why don't you tell us, Dr. Bayliss, what is glaucoma?

DR. BAYLISS: Well, it's a classification of diseases that the most common finding is the pressure going higher, which causes the optic nerve to slowly die from the inside out. And the tricky part about diagnosing it is that everybody has – we all have an optic nerve, this is the nerve right here, and we all have a space in the middle of the nerve, which we call a cup. Unfortunately, in terms of diagnosing glaucoma, that cup can get larger, and you wouldn't know it unless you saw someone on an emergent basis. So it's very difficult to determine whether or not a person is losing vision just by looking at the nerve. And we have a number of test, nerve fiber layer analyzing can also help. We're learning how to use that.

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JEANNE BLAKE: Help us understand nerve – what did you say?

DR. BAYLISS: Nerve fiber layer. All the retina collects at the optic nerve –

DR. SHINGLETON: This picture shows it real well. This, again, is, as Dr. Bayliss mentioned, what we're talking about now with glaucoma, this is real critical. Cataract, when we do an operation, we cure a cataract. It's gone. I remove that from the eye. Glaucoma refers to the pressure in the eye being too high, and we can't – we can lower the pressure, but glaucoma we have for a lifetime, and we control it. We can cure cataracts, we control glaucoma. But if you can picture it, the eye is a fluid-filled space and there's a pressure. Just like you have a blood pressure, you have an eye pressure. Sometimes that pressure can be too high for the health of the optic nerve at the back part of the eye. Here's a very nice schematic of the optic nerve, and if you can picture it, it's almost like a saucer with a central zone, and the nerves come out from this optic nerve and then layer out over the retina, and that's where the damage seems to occur. You actually lose nerve fiber. What we see clinically is a broadening of that cup, as Dr. Bayliss mentioned. Unfortunately for our patients, this is usually a silent stealer of vision, because it – in certain instances this can be a painful thing, but that's very rare. Most of the time, people don't know that it's happening. It changes so slowly, you adapt. You don't even know there's a change.

JEANNE BLAKE: There is a family history issue with glaucoma, so it's those folks who need to get in – can you talk about how often someone with a family history of glaucoma should be checked?

DR. SHINGLETON: It's very similar to macular degeneration. That critical time in the 40s, have a good baseline examination, and most people need it anyway for reading glasses. If they have a family history, we're probably talking every couple of years until they get into their 60s. Again, modified if people develop it an early age. We obviously look for certain changes when we examine the eye, there are certain things that we say, Gosh, this person needs to be followed more closely. But with a family history, certainly in their 60s we're watching people on an annual basis.

JEANNE BLAKE: Because glaucoma is controllable in nearly everyone. Is it in everyone?

DR. SHINGLETON: Everyone, but clearly there are a host of factors that go with it. But it truly is a preventable problem.

JEANNE BLAKE: We've only got a couple of minutes left. I'd love to talk with you about the research that you're doing right now in your office.

DR. SHINGLETON: Clearly, a lot of things are being done technologically. The cataract surgeries we're doing, we mentioned the 3mm ... incision, we're going smaller.

JEANNE BLAKE: Why?

DR. SHINGLETON: Because it's faster. Big incision, a lot of time. Small incision, same as laparoscopy for gallbladder, it's a big advantage. Lenses, we put the new lens inside the eye, we're developing technology that allows people to see without glasses, both near and far. That's a big advantage. Glaucoma, tremendous work we've done with medications, laser, where we use a lot of instrumentation for treatment of glaucoma and surgical techniques. We talked a little bit about the research in macular degeneration. And the last thing, just to whet people's appetite for future shows, is the surgery for nearsightedness, and that's tremendous, a whole new area for younger people.

JEANNE BLAKE: We're going to talk about that on another show, because a lot of people ask me what I think about that. And I need to get updated on that. But anyway, we're out of time, and as I said when we began this conversation, I love talking about the eyes. I don't think they get enough attention. What would we do without them? So I thank both of you for coming in today.

DR. BAYLISS: Thanks for having us.

JEANNE BLAKE: And we want to thank you for joining us on *About Health TV*. I'm Jeanne Blake, and we'll see you next time.

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