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Passion: The Force Driving Medicine

In the practice of medicine—particularly in our retina subspecialty—a persistent hum drives us forward. It resonates beneath our long hours in clinic, in the careful decisions of surgical precision, and in our conversations with patients who place their vision, and often their futures, in our hands. That hum is not simply duty. It is not exclusively intellect or even empathy. It is *passion.*

We speak often about innovation in medicine. About data. About precision. About outcome-driven care. But we speak too rarely—especially in our formal academic circles—about our passion, the emotional force that draws us to this work and keeps us engaged in it.

Passion is not an abstract quality but a measurable, definable, and indispensable element of what makes a physician not only effective, but enduring.

Nearly all of us enter medicine through a doorway shaped by motivation. For some, it begins with science: the marvel of human biology. For others, it originates with compassion—a desire to relieve suffering. Still others are inspired by mentors or family traditions. Regardless of the entry point, those who stay in medicine—who find fulfillment despite the pressure—share one key trait: a passion for the craft.

Passion in medicine is not a romanticized indulgence; it is a practical force. In clinical settings, passion translates to vigilance—catching details others might miss, persisting through difficult diagnostic journeys, and investing in a patient's experience as deeply as in their outcome. Passion sharpens our focus and improves our resilience. When metrics flatten us into productivity numbers or decision trees, passion keeps the patient human in our eyes.

In retina, we are often at the crossroads of irreversible decisions. A misstep in macular surgery, a delay in managing tractional retinal detachment, or a misread optical coherence tomography angiogram (OCTA) can have profound consequences. And yet, what I have seen in the most skilled retina specialists—and have witnessed among my colleagues in academia and private practice—is not a pursuit of perfection, but of purposeful care driven by deep engagement with their work.

Passion does not guarantee perfection; rather, it allows us as physicians to sit with the uncertainty of medicine. It makes us try again after complications, and it is why we read one more article before a complex case.

I recall vividly a conversation with a colleague who, after 30 years in practice, still found joy in reviewing fluorescein angiograms on a Friday evening—not because he had to, but because he *wanted* to. That is passion lived out in the rhythm of a clinical life.

Photo courtesy of Kevin Caldwell Photography.

If we accept that passion is essential, we must also ask ourselves, are we fostering our passion—or extinguishing it?

Today's medical education system is burdened. Learners are bombarded by standardized exams, compliance modules, and performance dashboards. Amid all of this, the space to cultivate wonder, curiosity, and purpose is narrowing. Yet that is exactly where passion lives.

Mentorship is the cornerstone of cultivating passion. I have had the privilege of working alongside residents and fellows who arrive brimming with questions and ideas. Those who thrive are not always the smartest or most efficient—but the most *engaged*. They light up in the operating room (OR). They seek feedback, not out of fear of failure but from a hunger to grow.

As educators, we must protect and promote passion. We do this by allowing trainees to connect with patients, to participate in real diagnostic uncertainty, and to witness not just procedures but the emotional highs and lows of patient care. When we create room for human experience—not just performance—we create clinicians who remain invested in their work for decades.

It would be disingenuous to discuss passion in medicine without acknowledging its darker cousin: burnout. Paradoxically,

often the most passionate physicians are most vulnerable to emotional exhaustion. When we care deeply, we are more affected by failure, loss, and systemic obstacles.

The solution is not to ask physicians to care less—but to support them more. Passion needs infrastructure: reasonable workloads, time for reflection, access to mentorship, and institutional cultures that value wellness as seriously as they do compliance.

Recent studies in *JVRD* and beyond have shown that physicians who retain autonomy in how we practice garner a sense of agency, making us more likely to maintain passion and avoid burnout. The implication is clear: passion thrives in environments of trust and support, not control.

In This Issue

This *JVRD* issue highlights 2 reports from the ASRS. The first, by Ali et al[1] for the Research and Safety in Therapeutics Committee, addresses concerns regarding "coring" of the vial stopper associated with drawing up intravitreal injections directly from a sterile medication vial. Fortunately, no safety issues have been reported, and the ASRS describes best practices. Of note, prefilled syringes avoid this concern in its entirety.

For the ASRS Health Economics Committee Al-khersan et al[2] describe supply chain volatility for repackaged bevacizumab for intravitreal injection. Repackaged bevacizumab is the most commonly injected intravitreal agent for treating vascular disease and macular edema. For off-label use, bevacizumab is employed in over 90% of all cases.

Access issues are noted to potentially compromise care for patients undergoing step therapy for coverage requirements and for virtually all patients not covered by a Food and Drug Administration-approved indication. The suggested action: suspend step therapy during access issues and understand the potential "unintended consequences" for limiting access and/or coverage of intravitreal bevacizumab.

Leung and colleagues[3] begin our original manuscripts, addressing the cost-effectiveness of treatments for diabetic macular edema. In this article, treatment was associated with significant benefit for all antivascular endothelial growth factor (anti-VEGF) medications.

Real-world data has also supported this benefit for quality-adjusted life years across all anti-VEGFs. Further analysis delves more deeply into the cost and impact of treatment—especially for individuals in the workforce.

Ammar and colleagues[4] evaluate surgical outcomes for primary, noncomplex retinal detachment in a young-adult cohort (age 20 to 45 years) focused on single-surgical success and "final" visual acuity (VA). This multicenter cohort study identified 165 eyes from the initial 260 cases. Of these eyes, 91 underwent scleral buckle (SB), 32 had pars plana vitrectomy (PPV), and 42 underwent combined SB/PPV.

Treatment selection appeared to favor SB for the "best" eyes, with PPV alone and then combined SB/PPV for the "worst" eyes. Overall, the combined single-surgery success rate was 85.3%: lowest for PPV alone (79.3%), intermediate for SB alone (83.7%), and highest for SB/PPV (92.7%). Complications were highest for SB (8.1%) and lowest for combined SB/PPV (2.4%). VA median was 20/25 for SB and 20/30 for PPV and SB/PPV.

One perspective on this study is that overall outcomes are excellent for this multicenter cohort, and retina surgeons should choose the procedure that achieves the best outcomes in their hands.

Bitra et al[5] report on risk factors for vitreous hemorrhage (VH) after PPV in the setting of proliferative diabetic retinopathy in 185 patients; 76 of 220 eyes had recurrent VH (34.5%). Younger age was associated with a higher likelihood of VH, while preoperative anti-VEGF was associated with a lower VH incidence. Fortunately, VH recurrence rates continue to drop from previous highs of 75%, but still occur in almost one-third of vitrectomized patients.

Montazeri and Emami-Naeini[6] evaluate Medicare Part B datasets between 2013 and 2021 to analyze trends and variations in retinal detachment repair. In this interval, procedures increased by 7.3% until 2020, when the COVID-19 pandemic resulted in an 11.1% decline, which never fully recovered by the study interval's conclusion in 2021. During this period, PPV accounted for 47% of all coded procedures.

Rush and Rush[7] address the issue of surgical repair of chronic, significantly visually limiting diabetic traction retinal detachment using a retrospective, case-controlled study. Of the 175 patients, 118 underwent vitrectomy with significant improvement in VA, while the control group experienced no improvement. In the control group of 57 eyes, no-light-perception vision developed in 17.5% compared with 5.9% of the vitrectomy group.

This study documents the surgical benefit of vitrectomy, but notes a higher risk of complications and lower postsurgical VA associated with these complex eyes and patients.

Liu et al[8] report on silicone oil (SO)-associated cystoid macular edema (CME) after PPV in 79 vitrectomized eyes, with 25.3% developing CME. In this series, SO viscosity appeared to be a risk factor for developing CME, which may resolve with oil removal in over 75% of patients.

Eton and colleagues[9] reported on outer retinal folds after PPV repair of rhegmatogenous retinal detachment, which occurred in 19.2% of study eyes. Outer retinal folds typically resolved by 4 months postsurgery and did not impact final VA.

Al-Assil et al[10] report outcomes for autologous retinal transplant in refractory macular holes in 9 patients. Macular hole closure occurred in 89% of eyes, with 3 of 9 eyes experiencing flap dislocation. VA improved to 20/200 from 20/1600; proliferative vitreoretinopathy occurred in 11.1% of study eyes.

De Clerck and colleagues[11] describe the impact of single-use widefield viewing lenses during vitrectomy surgery. In the 181 patients, single-use lenses achieved enhanced viewing and decreased condensation compared with existing reusable lens systems. The authors posited that the wide-angle lens enables high-resolution macular surgery without compromise, potentially minimizing the need for viewing-lens changes for peripheral vs macular surgery.

Mansour and colleagues[12] compare intravitreal delivery approaches for high-dose aflibercept in 32 eyes of 30 patients. This study suggests that increasing the volume of injected drug is a viable strategy to adjust treatment dose for both aflibercept and ziv-aflibercept.

Okawa et al[13] evaluate real-world performance of faricimab in treatment-naïve neovascular age-related macular degeneration (nAMD) patients through one year using a treat-and-adjust protocol. Forty-six study eyes were evaluated; the series noted both improved anatomical and visual outcomes, with 76.9% of patients experiencing complete polyp regression.

Khaohoen and Chantarasorn[14] describe the OCTA and clinical features of nAMD and pachychoroid neovasculopathy in 108 patients; they note that pachychoroid patients were younger and had increased polypoidal lesions and a central serous chorioretinopathy-like overlap.

Dhoot and colleagues[15] update the VIEW trials with a focus on the impact of central subfield thickness (CST) fluctuations on visual outcomes. In VIEW 1 and VIEW 2, higher fluctuations in CST—irrespective of anti-VEGF agent or treatment regimen—were associated with lower VA gains. This unique study dataset brings significant focus, even when employing a post hoc analysis approach to non-primary outcomes.

Hoyek et al[16] compare adult and pediatric eyes with Coats disease, employing multimodal imaging in 18 patients. As expected, children typically present with more-advanced stages of Coats disease, greater macular involvement, and lower VA. OCTA revealed adults had lower vessel density of both the superficial and deep capillary plexuses than the noninvolved fellow eye.

Scripsema and colleagues[17] report the impact of ultra-widefield fluorescein angiography (UWFA) on the diagnosis and management of diabetic retinopathy. In this study, 10 experts were asked to grade 20 patients' fundus imagery and then were surveyed for the impact of UWFA on diagnostic classification and requested treatment; 39% of respondents shifted from recommended observation to treatment—a critical evaluator of testing impact.

Sverdlichenko et al[18] present an overview of radiation retinopathy in the setting of whole-brain radiotherapy. In this case and review, median radiation dose was 40.7 Gy and median time to visual symptoms was 20.5 months. Patients who received chemotherapy in the setting of whole-brain radiotherapy appeared to have a greater risk. Serial post-radiotherapy OCT has the potential to improve diagnosis of radiation retinopathy and enhance early recognition and treatment for this potentially devastating condition.

Dhillon and MacLeod[19] report a case series of bilateral intraocular inflammation after intravitreal faricimab in the United Kingdom; they propose that this occurrence may be higher than previously reported, suggesting an incidence of 8.5% for bilateral injections.

Shen and colleagues[20] report a retrospective review of eyes undergoing SO removal, identifying 980 eyes with 2.9% experiencing severe SO migration. The authors note that internal limiting membrane removal is associated with SO migration and further note that OCT imaging after SO placement may enhance early detection of severe intraretinal SO migration.

Pappas et al[21] report the intracranial extension of SO in a 52-year-old patient with diabetes. The authors postulate that elevation in intraocular pressure and long-term SO retention may predispose patients to this complication.

Wolek et al[22] describe en face OCT and OCTA imaging to detect, and monitor, posterior placoid syphilitic lesions. These findings of hyperreflective lesions and nonperfusion of the choriocapillaris persisted beyond the clinical resolution of the placoid chorioretinopathy.

Allan et al[23] report a case of irreversible vision loss secondary to CME occurring with paclitaxel therapy for metastatic breast adenocarcinoma. The authors postulate that type 2 macular telangiectasia predisposed this 61-year-old woman to severe vision loss in the setting of secondary CME.

Lin and colleagues[24] present an 82-year-old woman with sarcoid uveitis treated with faricimab after systemic and topical steroid treatment. CME refractory to therapy responded to intravitreal faricimab and the patient's VA improved.

Sheth et al[25] present the case of a 77-year-old man with a history of testicular, diffuse large B-cell lymphoma believed to be in remission. Initially, the patient was felt to have peripheral exudative hemorrhagic chorioretinopathy, but experienced a severe bilateral decline in VA.

The patient underwent a nondiagnostic vitrectomy, after which magnetic resonance imaging (MRI) revealed a 7 mm thalamic lesion; he then underwent stereotactic brain biopsy, which documented a recurrence of the lymphoma. Systemic therapy recovered vision and resolved the recurrent lymphoma.

At the authors' institution, brain involvement almost always requires biopsy, even in the setting of a diagnostically positive vitrectomy. This has prompted MRI imaging prior to vitrectomy to limit surgical intervention to a single biopsy, typically brain.

Alenazi et al[26] present the 2-year outcome for amniotic membrane patch grafting in the surgical management of 3 patients with optic pit maculopathy. The authors note persistence and stability of the amniotic membrane in all 3 patients and suggest this approach for optic pit maculopathy.

We conclude our case reports with Gao and colleagues,[27] who present a 77-year-old patient with VEXAS syndrome and describe optic disc edema in the presentation. VEXAS syndrome is an autoinflammatory disease typically seen in men over the age of 50 years, associated with X-linked somatic mutation of the *UBA1* gene. Increasing both systemic prednisone and methotrexate led to improvement of his optic disc edema and systemic symptoms.

There is something uniquely powerful about practicing retina. We operate in millimeters. We wield lasers and biologics with elegance and precision. We restore sight—one of the most vital human senses—sometimes in cases where others have given up.

Our field, more than many others, allows us to see an immediate impact. A patient who walks into clinic legally blind due to macular hemorrhage may walk out weeks later reading

again after anti-VEGF therapy. That immediacy is intoxicating—and sustaining.

Retina, as a discipline, is uniquely suited to passion-driven care. It demands technical excellence, yes—but also courage, creativity, and deep attention. It is why our field continues to draw exceptional trainees and to innovate at the boundaries of medicine and technology.

Let us not lose sight of what makes retina not only advanced, but *alive*—our passionate investment in each detail of care, from the OR to the imaging suite.

Can something as intangible as passion be built into systems? I believe it can—and must be.

At *JVRD*, we have intentionally cultivated a publishing environment that invites curiosity, debate, and voice. We highlight not only landmark original manuscripts but also case series and reports, reviews, and editorials—forms of scholarly communication that allow passion to be expressed. We have created space for younger physicians, for global voices, and for work that challenges dogma. Passion shows up in *how* and *why* we publish—not just *what* we publish.

At the ASRS and in peer-reviewed academic circles, we must continue to recognize that as physicians, we are not only scientists; we are thinkers, leaders, and humans who bring our full selves to our work. Our professional structures must allow room for that full expression.

When we look back at the physicians we admire, it is rarely their procedural numbers or clinic throughput we remember. It is their presence. Their commitment. Their passion.

As I near 4 decades in this field, I know that it is not the titles or accolades that sustain a life in medicine. It is the morning I was able to deliver good news after weeks of uncertainty; the fellow in training who found a footing in retina and called to say "thank you;" the moment of stillness during a case, when the macula clears and we both—patient and surgeon—know something profound just happened. These are moments built on passion. And they are the currency of a meaningful career.

In retina, as in all of medicine, we must learn not only to diagnose and treat, but to remember why we began. We must protect passion—not as an accessory to practice, but as its core. We must teach it, share it, and return to it when the days get long.

If you are just starting in this field, nurture your passion. It will serve you when knowledge fails and systems disappoint. If you are deep in practice, reconnect with your passion. Let it guide your teaching, your leadership, and your moments of doubt. And if you are near the end of your career, share your passion. Let it be your most enduring legacy.

In every patient encounter, every surgery, and every moment of difficult decision-making, may we be guided not only by what we know—but by what we love about this work. That is how we sustain medicine, and ourselves.

Ultimately, what drew me to medicine was purpose—but what drove me to ocular oncology and retina was the passion to advance care for our patients and to eliminate suffering from life-threatening and potentially blinding disease.

'It is not how much we do, but how much love we put into doing it.'
—Mother Teresa

'The only way to do great work is to love what you do.'
—Steve Jobs

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References

1. Ali FS, Schneider EW, Arepalli S, et al. Coring of intravitreal medication vial stoppers: a report from the Research and Safety in Therapeutics Committee of the American Society of Retina Specialists. *J Vitreoretin Dis*. 2025;9(5):546-549.
2. Al-khersan H, Busquets M, Ghorayeb G, et al. Supply chain volatility of repackaged intravitreal bevacizumab: a survey of the American Society of Retina Specialists. *J Vitreoretin Dis*. 2025;9(5):550-554.
3. Leung EH, Grewal DS, Gerbi E, et al. Cost-effectiveness of treatments for diabetic macular edema: simulated bevacizumab-first step therapy versus real-world practice. *J Vitreoretin Dis*. 2025;9(5): 555-565.
4. Ammar MJ, Lee JJ, Cai L, et al. Surgical outcomes of primary noncomplex rhegmatogenous retinal detachment in 20- to 45-year-old young adults. *J Vitreoretin Dis*. 2025;9(5):566-574.
5. Bitra J, Sureshkumar H, Eathara AV, Alahmadi R, Heiferman MJ. Risk factors for recurrent vitreous hemorrhage after 25-gauge pars plana vitrectomy in patients with proliferative diabetic retinopathy. *J Vitreoretin Dis*. 2025;9(5):575-583.
6. Montazeri F, Emami-Naeini P. Temporal trends and regional variations in retinal detachment repair procedures in the United States from 2013 to 2021. *J Vitreoretin Dis*. 2025;9(5):584-591.
7. Rush RB, Rush SW. Chronic diabetic tractional retinal detachment and poor visual acuity: should we be performing surgery on these patients? *J Vitreoretin Dis*. 2025;9(5):592-598.
8. Liu J, Wirostko W, Ahmad B. Incidence of and risk factors for silicone oil–associated cystoid macular edema after pars plana vitrectomy. *J Vitreoretin Dis*. 2025;9(5):599-606.
9. Eton EA, Pan WW, Besirli CG, Zacks DN, Wubben TJ. Incidence and impact of outer retinal folds after pars plana vitrectomy for primary rhegmatogenous retinal detachment repair. *J Vitreoretin Dis*. 2025;9(5):607-613.
10. Al-Assil T, Vogt D, Wolf A, et al. Autologous retinal transplant in refractory macular holes. *J Vitreoretin Dis*. 2025;9(5):614-621.
11. De Clerck I, Van Calster J, Stalmans P. Clinical performance of novel single-use lenses in vitreoretinal surgery. *J Vitreoretin Dis*. 2025;9(5):622-627.

12. Mansour AM, Lima LH, Parodi MB, Casella AMB, Cherfan DG, Arevalo JF. Outcomes of and surgical technique for treatment with high-dose aflibercept. *J Vitreoretin Dis*. 2025;9(5):628-631.
13. Okawa K, Maruyama-Inoue M, Chin JY, Inoue T, Yanagi Y, Kadonosono K. One-year outcomes of intravitreal faricimab injection in treatment-naïve patients with neovascular age-related macular degeneration. *J Vitreoretin Dis*. 2025;9(5):632-638.
14. Khaohoen A, Chantarasorn Y. Clinical features and optical coherence tomography angiography in neovascular age-related macular degeneration and pachychoroid neovasculopathy. *J Vitreoretin Dis*. 2025;9(5):639-650.
15. Dhoot DS, Shah CP, Silva FQ, et al. Impact of central subfield thickness fluctuations on visual outcomes in neovascular age-related macular degeneration in the VIEW trials. *J Vitreoretin Dis*. 2025;9(5):651-658.
16. Hoyek S, Patel NA, Parikh AA, Yaghy A, Mukai S, Baumal CR. Comparison of adult and pediatric eyes with coats disease using multimodal imaging. *J Vitreoretin Dis*. 2025;9(5):659-666.
17. Scripsema NK, Al-Khaled T, Song A, et al. The influence of ultra-widefield fluorescein angiography on the diagnosis and management of diabetic retinopathy. *J Vitreoretin Dis*. 2025;9(5):667-677.
18. Sverdlichenko I, Tayeb S, Narmandakh A, Margolin E, Tsang DS, Yan P. Radiation retinopathy after whole-brain radiotherapy in a patient with pineal gland tumor. *J Vitreoretin Dis*. 2025;9(5):678-686.
19. Dhillon N, MacLeod S. Intraocular inflammation following intravitreal faricimab: insights from five bilateral cases. *J Vitreoretin Dis*. 2025;9(5):687-691.
20. Shen C, Liu D, Chen C, et al. Clinical and optical coherence tomography characteristics of severe intraretinal silicone oil migration. *J Vitreoretin Dis*. 2025;9(5):692-698.
21. Pappas CP, Waldie AM, Shah PR. From vitreous to ventricles: serial imaging of intracranial silicone oil migration. *J Vitreoretin Dis*. 2025;9(5):699-702.
22. Wolek M, Paul S, Seraly M, Mehra A, Sobol W. En face optical coherence tomography and optical coherence tomography angiography for the diagnosis and monitoring of syphilitic posterior placoid chorioretinopathy. *J Vitreoretin Dis*. 2025;9(5):703-708.
23. Allan KC, Kindy AE, Yuan A. Occam versus hickam: irreversible vision loss from paclitaxel-induced cystoid macular edema. *J Vitreoretin Dis*. 2025;9(5):709-711.
24. Lin T-H, Lin HY, Chuang Y-H, Tseng P-C. Faricimab as treatment for sarcoid uveitis with refractory cystoid macular edema. *J Vitreoretin Dis*. 2025;9(5):712-716.
25. Sheth N, De Alba M, Challa N, Massengill MT, Mieler WF. Diagnosis of secondary vitreoretinal lymphoma with neurosurgical stereotactic biopsy: a multimodal diagnostic and imaging approach. *J Vitreoretin Dis*. 2025;9(5):717-721.
26. Alenazi M, Mura M, Alakeely AG, Al-Qahtani FS. Human amniotic membrane patch for optic disc pit maculopathy remains integrated at 2 years. *J Vitreoretin Dis*. 2025;9(5):722-726.
27. Gao MA, Liu T, Randhawa S. A novel case of optic disc edema associated with VEXAS syndrome. *J Vitreoretin Dis*. 2025;9(5):727-730.