CHASE THE VISION, NOT THE SUPPORT. THE SUPPORT WILL END UP FOLLOWING YOU.

RESEARCH STRATEGY
Unlike many larger research institutions, our research model is to identify a problem directly impacting those with vision problems now and immediately address those problems.

Many institutions are bound by layers of red tape. Their model may include identifying a funding source and then trying to find an issue they can address that fits that funders criteria.

Our model allows a direct and immediate impact for those with vision challenges. Life is short; providing people with the best vision possible is our top priority.

ABOUT US
The Cornea Research Foundation of America, a 501(c)3 nonprofit (ID: 31-1243592), was founded in 1988 by Francis W. Price, Jr., MD, with a focus on advancing cornea transplant outcomes. Since that time, our pioneering work in developing new techniques has helped change the way we treat people with Fuchs’ dystrophy, keratoconus, glaucoma and more.

"That all who look may see."®
C O R N E A . O R G

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BOARD OF DIRECTORS
July 1, 2017 - June 30, 2018

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**ISN’T IT AMAZING?**

Without vision research conducted over the last 30 years at the Cornea Research Foundation of America and other institutions, many new advances in vision care may not have been possible.

More people would have faced severe visual challenges with full-thickness cornea transplants, rather than the fast-healing DSEK and DMEK transplants. Developments in the treatment of glaucoma, cataracts and many other problems would still be in the dark ages of ophthalmology. Young people would still be in glasses or more susceptible to infection through contact lens use rather than having one-time LASIK refractive surgery to optimize their vision. There would be fewer allergy and dry eye medications to treat those chronically irritating conditions. Transplant patients would be on stronger steroids causing additional complications, and more.

We are so thankful to the many research partners, and our supporters who, for the past 30 years have helped us pave the way for innovation through better vision correction treatments and medications. What’s next?

**CAN YOU IMAGINE?**

Using eye drops or a single injection of cells to rejuvenate a cornea instead of a transplant? An eye drop to keep Fuchs’ dystrophy from progressing? A time when glaucoma doesn’t steal sight?

We can imagine. Join us today.

**Our Strategic Goals Include:**

- Pioneering improvements in cornea transplants to improve outcomes for patients and families
- Providing new vision restorative treatments to patients through clinical studies
- Leading education for ophthalmic surgeons, optometrists and patients

*“That all who look may see.”®*

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“I consider myself deeply fortunate that my transplant was successful but what I think is even more amazing is that Dr. Price, though his research and surgical skills, has made this readily available to so many people worldwide.”

Dr. Lynn Mitchell  
Patient of Dr. Price
EXECUTIVE STATEMENT

Thanks to the support of people like you, the Cornea Research Foundation of America has made significant advances in treating vision impairment caused by conditions that afflict the front part of the eye, including Fuchs' dystrophy, keratoconus and glaucoma. Our 30-year track record of clinical research has helped develop and refine cornea transplant techniques by providing better visual outcomes to patients. We look forward to a future where even less invasive treatments may be an option and appreciate your support to help us reach that goal.

In this report, we share key activities for the fiscal year ended June 30, 2018. We strive for transparency and excellence in stewardship of your investment in sight-restoring research and appreciate your time in reviewing this report.

In the fiscal year ended June 30, 2018, we shared our findings in 11 journal publications (page 15) and 36 presentations to surgeons at international eye meetings (page 18).

RESEARCH FOCUS

A key focus of our research has been: How can we prevent up to 30% of patients from experiencing steroid-induced glaucoma? After all we don’t want to solve one problem, Fuchs’ dystrophy, with a cornea transplant and ultimately create another problem, glaucoma.

Our series of studies to optimize steroid eye drop dosing and duration for prevention of transplant rejection significantly reduced steroid complications. However, some patients still develop high pressure in the eye, known as elevated intraocular pressure or IOP. Therefore, we initiated 2 additional studies:

- **Fuchs’ Genetic Study**: This National Eye Institute funded study is investigating the genetic reasons why patients experience steroid-induced glaucoma. We are enrolling 800 patients who had DMEK or DSEK, took Pred forte®1% for at least a year and are willing to provide a saliva sample for analysis. Can we create a genetic test that will identify who is at risk? This study may also shed light on the genetic basis of open-angle glaucoma.

- **Rock Inhibitor Study**: This study is evaluating whether a new drop used in combination with the steroids prescribed after a transplant can prevent steroid-induced glaucoma (which occurs in up to 30% of patients). Graft rejection is a serious risk for transplant failure. The steroids used to prevent it can cause the eye's drain to clog, causing elevated pressure. We have investigated reducing or stopping drops, but this is the first study which adds a preventative drop to our post-operative regimen.

LOOKING AHEAD: 2020 AND BEYOND

We have a series of studies underway to investigate a multitude of areas impacting the front part of the eye (page 8). You may have heard of a new procedure which may serve as a substitute for Descemet’s Membrane Endothelial Keratoplasty (DMEK). This procedure, known as Descemet Stripping Only (DSO) or Descemet’s Stripping Without Endothelial Keratoplasty (DSWEK), is a hot topic right now. Wouldn’t it be wonderful to be able to avoid the need for a cornea transplant? If so, no anti-rejection medications would be necessary, eliminating the most common transplant complication of high intraocular pressure which can lead to glaucoma. We share an in-depth review of this newer procedure (page 10).

In addition to improvements in transplant health, we plan to address several other areas. We plan to address an unmet need by evaluating a new treatment for patients who are unusually far-sighted. The current treatment options for these patients are limited and fraught with possible risk.

Following up on our discovery that traditional glaucoma drainage devices severely curtail cornea transplant survival and create a toxic environment in the front part of the eye, we plan to evaluate the impact of an exciting new glaucoma device.

Nearsightedness is increasing worldwide and is now estimated to affect 4 out of 10 Americans. Children typically begin to become near-sighted during grade school. We plan to evaluate a non-invasive “off-the-shelf” treatment to potentially prevent near-sightedness from ever developing.

With sincere appreciation of your support,
ADDITIONAL CURRENT STUDIES

In addition to the ROCK Inhibitor Study to Prevent Cornea Transplant Complications and the Fuchs’ Genetic Study, we have several other initiatives underway, including:

Further refine DMEK in new analyses
We continue to improve DMEK through new imaging methods, tissue insertion techniques and more, to optimize visual outcomes.

Finding causes of Fuchs’ and keratoconus
We collect corneal tissue from transplant patients to help identify the underlying causes of these two leading causes of corneal transplantation.

New treatments to alleviate painful dry eye
Dry eye is common, affecting 10% of the population, and can be debilitating, particularly after eye surgery. We continue to investigate new, innovative treatments.

Artificial Iris implant study
We showed this implant helped people with congenital aniridia or traumatic eye injuries, resulting in U.S. FDA “breakthrough device” approval in 2018!

Contact-lens related eye infections
We are conducting a genetic study to find out why certain people are more susceptible to contact lens-related eye infections.

New Treatment for eyelid lesions in children
This painful condition can cause significant visual problems. We are evaluating drops to encourage healing and prevent recurrence.

COLLABORATIONS.
Joining together with others helps multiply the probabilities of success by maximizing each other’s strengths.

Case Western Reserve University
Indiana University
Massachusetts Eye & Ear at Harvard Medical School
Tufts University
University of Chicago
BEYOND A TRANSPLANT:
NEW TREATMENT FOR FUCHS' DYSTROPHY IN DEVELOPMENT

We are always looking for better ways to help patients with Fuchs' dystrophy. That is why we helped lead the evolution of corneal transplants from full thickness grafts (penetrating keratoplasty) to PLK/DLEK to DSEK to DMEK. Interest is building now to eliminate the transplant altogether and allow a person's own endothelial cells to regenerate in a procedure called Descemet Stripping Only (DSO) or DWEK (Descemet Stripping Without Endothelial Keratoplasty).

The corneal endothelium is a single layer of cells that lines the back surface of the cornea. These cells pump water out of the cornea to keep it clear. In Fuchs' dystrophy the corneal endothelial cells become unhealthy and die off, starting in the center and moving outward over time. This allows fluid to build up in the cornea causing swelling and hazy vision.

The corneal endothelial cells are attached to a thin membrane called Descemet's membrane. In Fuchs' dystrophy, abnormal deposits called “guttae” accumulate on Descemet's membrane. These deposits cause glare and impair vision. Currently the only way to restore vision is with a transplant.

A healthy endothelium compared to a diseased endothelium. These guttæ are like water drops on a windshield (guttæ mean raindrops in Latin). They distort the light coming into the cornea and also cause glare and halos and must be removed to improve vision.

With DMEK, only the back endothelial layer on Descemet's Membrane is transplanted. It's just ~20 microns thick!

With DSO, only a smaller area of Descemet's membrane is removed along with the guttæ causing vision loss and no donor endothelium is transplanted.

During the next few weeks to months, endothelial cells from the peripheral cornea start to move in and repopulate the central cornea. DSO is a redistribution of existing cells. With DMEK, unhealthy cells are replaced with donor cells through the transplanted tissue.

Two potential benefits of DSO excite us:

First, there is no risk of graft rejection (0% rejection rate) because we are not putting a graft into the eye. Second, patients would not need to use anti-rejection eye drops long-term, thereby reducing their risk of developing high intraocular pressure and glaucoma risk. We know that the primary complication for cornea transplants is high intraocular pressure with long-term steroid use.

Concerns and areas for further optimization are:

- With DSO the rate of corneal clearing is less predictable and generally slower than it is with DMEK. DSO requires more patience from patients.
- The area treated with DSO is relatively small – it's only ¼ as large as the area we treat with DMEK. A small treatment zone (about 4 mm diameter) facilitates corneal clearing, but the guttæ will continue to progress outside of the treated area. Our biggest concern is with glare and quality of vision at night, when the pupil is dilated, because many people have a dilated pupil diameter larger than 4 mm. We've found that the lenses we implant with cataract surgery need to have an optical zone at least 6 mm in diameter to avoid glare and haloes at night, but cornea clearing after DSO is slower and less reliable with a 6-mm treatment zone.
- A third concern is that corneal endothelial cells do not seem to regenerate after early childhood, so the cells that move in from the periphery to repopulate the central cornea after DSO are older adult cells affected by Fuchs' dystrophy. We aren't sure how soon these aging cells will deposit guttæ and how long they will be able to maintain corneal clarity. DSO may be a strategy for delaying the need for a cornea transplant.

We are pleased to offer DSO to interested patients with our research partner, Price Vision Group, as we continue to work to optimize the outcomes.

Looking ahead, cell culture techniques are improving, and someday we may be able to harvest stem cells from your blood and reprogram them to become corneal endothelial cells. In the meantime, DMEK is an excellent option for rapid visual improvement and rehabilitation.

We certainly live in an exciting time with advancements occurring continually around the world. So stay tuned!
**TREASURER’S REPORT**

For the fiscal year ended June 30, 2018, the Cornea Research Foundation reported total revenue of $558,452. This was less than the total revenue of $747,857 in the prior year, primarily due to an anticipated reduction in research study revenue from sponsored studies.

Expenses totaled $465,813 compared to $566,428 the prior year. The $100,000 decrease was anticipated due to the planned decrease in participation of sponsored studies for the year.

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**BALANCE SHEET**

<table>
<thead>
<tr>
<th>Assets</th>
<th>2018</th>
<th>2017</th>
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</thead>
<tbody>
<tr>
<td>CURRENT ASSETS</td>
<td></td>
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<tr>
<td>Cash and Cash Equivalents</td>
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<td>Investments</td>
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<td>Accounts Receivable</td>
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<td>Total Current Assets</td>
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<td>PROPERTY AND EQUIPMENT, AT COST</td>
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<tr>
<td>Property and Equipment</td>
<td>141,926</td>
<td>141,926</td>
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<tr>
<td>Less: Accumulated Depreciation</td>
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<td>(134,947)</td>
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<td>Property and Equipment, Net</td>
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<tr>
<td>Total Assets</td>
<td>$1,152,687</td>
<td>$1,054,347</td>
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</table>

| Liabilities and Net Assets    |               |               |
| CURRENT LIABILITIES           |               |               |
| Accounts Payable              | 12,396        | 3,037         |
| Accrued Payroll and Other Liabilities | 14,467   | 18,104        |
| Total Current Liabilities     | 26,863        | 21,141        |

| NET ASSETS                    |               |               |
| Unrestricted                  | 1,125,824     | 1,025,435     |
| Temporarily Restricted        | 7,750         |               |
| Total Net Assets              | 1,125,824     | 1,025,435     |

| Total Liabilities and Net Assets | $1,152,687 | $1,033,185 |

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**ANNUAL FINANCIAL REVIEW**

Our annual financial review for the fiscal year ending 6/30/18 was conducted by CliftonLarsonAllen, LLP, in accordance with Statements on Standards for Accounting and Review Services.

**DIRECT PROGRAM**

CliftonLarsonAllen determined 91 percent of funds received supported direct research and educational program services which is consistent with prior years.

**$1M+ TOTAL ASSETS**

2017 marked the first time in our 30 year history with net assets over $1M positioning CRFA towards improving current treatment options for complex conditions.

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**STATEMENT OF ACTIVITIES**

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
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</thead>
<tbody>
<tr>
<td>REVENUE AND CONTRIBUTED SUPPORT</td>
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<tr>
<td>Contributions</td>
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<td>Research Study Income</td>
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<td>Seminar Income</td>
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<td>Golf Classic Sponsorship and Other</td>
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<td>In-Kind Contributions</td>
<td>90,311</td>
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<td>Interest Income</td>
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<td>Net Realized and Unrealized Loss on Investments</td>
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<td>(14,065)</td>
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<tr>
<td>Net Assets Released from Restriction</td>
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</tr>
<tr>
<td>Total Revenue and Contributed Support</td>
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<td>$747,857</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
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<tr>
<td>Program Services</td>
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<td>520,745</td>
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<td>Supporting Services:</td>
<td></td>
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<tr>
<td>Management &amp; General</td>
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<td>26,708</td>
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<tr>
<td>Fundraising</td>
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<td>18,975</td>
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<tr>
<td>Total Expenses</td>
<td>$465,813</td>
<td>$566,428</td>
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</table>

<table>
<thead>
<tr>
<th>CHANGE IN NET ASSETS</th>
<th>2018</th>
<th>2017</th>
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</thead>
<tbody>
<tr>
<td>Net Assets - Beginning of Year</td>
<td>1,133,185</td>
<td>851,756</td>
</tr>
<tr>
<td>NET ASSETS – END OF YEAR</td>
<td>$1,125,824</td>
<td>$1,033,185</td>
</tr>
</tbody>
</table>

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**OUR SOURCES OF INCOME**

Our annual financial review for the fiscal year ended 6/30/18 was conducted by CliftonLarsonAllen, LLP, in accordance with Statements on Standards for Accounting and Review Services.

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**HOW WE STEWARD OUR FUNDS**

- **Fundraising** 4%
- **Program Services** 91%
- **Management & General** 5%

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**OUR SOURCES OF INCOME**

**Contributions 49%**
- **Research Study Income 17%**
- **Seminar Income 5%**
- **Golf Outing 9%**
- **In-Kind Contributions 16%**
- **Interest Income 4%**
Annual Report 2017/18

RESEARCH: HOW IT WORKS

Highly effective research begins with making good decisions about which studies to conduct, maximizing the return of your time and financial investment. We do our best to steward our contributions wisely and conduct truly innovative research by staying current on the research others are performing and addressing the most pressing problems our patients currently face.

Study Setup & Patient Enrollment
Our studies are monitored by an Independent Review Board (IRB) to ensure compliance with regulations. Patients are then enrolled via online and/or in-clinic invitation.

Collaborations
Since we do not have a laboratory on site, we often partner with research institutions who have similar interests with lab capabilities.

Identify Opportunities
We identify study opportunities through patient observations in our partner clinic, Price Vision Group, at eye meetings around the globe, or via personal invitation.

Share, Share, Share
We share findings of our studies through all relevant channels including journal publications, website and live presentations to ensure maximum reach. Through sharing of study findings, we often identify new partners via dynamic discussions at eye meetings.

Results Analyzed
We analyze the results to learn if our hypothesis was accurate. In some cases, additional studies are developed based on the findings of a study.

RESEARCH: PUBLICATIONS

Leading eye journals select research manuscripts based on subject matter, innovation, and anticipated impact. Our findings are selected for publication at a higher rate than many institutions because we work quickly to design, implement, conduct innovative studies, and prepare our findings in a timely manner to stay on the cutting edge.


CONCLUSIONS: This two-part study compared the 5-year survival rates of DMEK vs. DSEK, and evaluated whether matching the donor and recipient sex affects the number of rejection episodes and graft survival. We reviewed 2,017 consecutive cases (1,312 DSEK and 705 DMEK) performed by 13 surgeons between 2003 and 2012 and included the surgeons’ first cases.

Our first important finding was that DMEK and DSEK both had favorable 5-year survival rates of 93%. The risk of experiencing a graft rejection episode was higher with DSEK (8% in 5 years vs. 3% with DMEK), but most rejection episodes were mild and the graft usually could be saved with increased corticosteroid eye drops.

Our second important finding was that sex matching the donor and recipient provided no survival advantage with DSEK or DMEK. This finding was in direct contrast to a widely-publicized study from the UK which suggested that female patients with Fuchs’ dystrophy experience better graft survival if they receive a donor cornea from a female rather than a male. A key difference between our study and the UK study was that theirs primarily included full thickness grafts, which have much higher rates of graft rejection. Given that Fuchs’ dystrophy patients are more likely to be female and tissue donors are more likely to be male, the logistics of sex-matching donors and recipients would be challenging. Our findings provide reassurance that Fuchs’ dystrophy patients can expect high graft survival rates with DSEK and DMEK, regardless of the donor sex.


CONCLUSIONS: Surgeons have developed different methods of inserting DMEK grafts into patients’ eyes, and often feel their personal method is superior. We performed a head-to-head comparison of different insertion methods in 754 consecutive DMEK cases performed by 2 experienced surgeons to treat Fuchs’ dystrophy.

We found that the results were similar with different methods of folding or curling the graft for insertion, suggesting that the choice is a matter of surgeon preference. This type of careful comparison is important as we continue to refine DMEK and educate surgeons who have just begun their DMEK training.

Continued...
CONCLUSIONS: Fuchs' dystrophy is characterized by drop-like deposits called guttae that form on a layer of the cornea called Descemet's membrane. These deposits distort vision and cause the endothelial cells, which adhere to Descemet's membrane to die, eventually causing the cornea to become cloudy. This study evaluated the effect of guttae diameter and found that larger guttae have a more negative impact on endothelial cell adherence and survival. Thus removal of large guttae would be necessary to facilitate repopulation of the endothelial cell layer using cell therapy approaches as well as for optimal visual rehabilitation.


CONCLUSIONS: This study investigated the effect of oxidative stress on the corneal endothelium in Fuchs' dystrophy and identified an agent which blocked key stress-induced changes.


CONCLUSIONS: In this invited review of the field, we note that cornea transplant longevity is often determined by the health of the endothelial cells lining the inner surface of the cornea. Whenever other layers of the cornea need to be replaced but the endothelium is healthy, the transplant will survive longer if the surgeon uses a transplant technique, such as deep anterior lamellar keratoplasty (DALK), which retains the patients' own endothelium. In cases where the endothelial cell layer is dysfunctional, selective replacement of that layer through a small incision with DMEK or DSEK is far safer and provides much faster visual recovery than a full thickness transplant. With a cornea transplant, early endothelial cell loss is primarily associated with donor tissue preparation and surgical technique, while the greatest risk factor for longer-term endothelial failure is prior glaucoma filtration surgery.


CONCLUSIONS: This study evaluated whether the use of hypoxia (low oxygen) preconditioning can reduce the damage to donor corneas as they are being prepared and inserted during a simulated transplant procedure. We found that hypoxia preconditioning or incubation with FG-4592, a chemical that stimulates a similar protective response, did help protect corneal endothelial cells from death by mechanical stress. Hypoxia-preconditioned human and rabbit corneas showed 19% and 29% less cell loss, respectively, relative to controls, which were both significant at P < 0.05. Likewise, FG-4592 preconditioning reduced endothelial cell loss associated with preparation and insertion of DSAEK grafts by 23% relative to the control (P < 0.01).


CONCLUSIONS: Most donor corneas are harvested in a hospital setting, and the incidence of hospital-acquired fungal infections is increasing, as are the rates of positive fungal cultures from corneal donor tissue. The risk of post-keratoplastic fungal infection is still low, but creeping up, and these infections are very difficult to treat. We recently treated a donor-associated fungal infection with heavy use of anti-fungal medications plus surgical removal of the fungal colony and adjacent portion of the graft. This successfully eradicated the infection without graft replacement.


CONCLUSIONS: Occasionally there is bleeding inside the eye (hyphema) with DMEK. This study evaluated potential risk factors and outcomes. We found that preoperative use of anticoagulant or antiplatelet medication (such as warfarin or aspirin) was not a significant risk factor for hyphema, suggesting that it is not necessary to routinely stop the use of such medications before surgery. Importantly, we found that experiencing hyphema did not significantly affect graft attachment, endothelial cell loss, or visual acuity outcomes.


CONCLUSIONS: Corneal cross-linking helps strengthen the cornea to prevent it from becoming further misshapen for patients with keratoconus. Importantly, it can help prevent the need for an invasive cornea transplant. Cross-linking involves application of riboflavin (vitamin B) eye drops to the eye and exposure to UV light to trigger a photochemical reaction. We investigated two riboflavin dosing regimens and determined they both produced an equivalent flattening of the bulging associated with keratoconus and both presented favorable safety profiles.


CONCLUSIONS: Corneal cross-linking was approved in the United States for treatment of keratoconus in 2016. We had conducted cross-linking studies for 8 years prior to approval and were interested in assessing patient satisfaction with the procedure over time. Therefore, we invited 552 patients to complete an electronic survey and were very pleased with the high participation rate (80%). We found that most patients considered cross-linking to be effective. Satisfaction rates were highest (over 90%) among those who had crosslinking at a younger age and/or earlier stage of keratoconus. This makes sense because crosslinking strengthens the cornea to prevent further keratoconus progression but it does not necessarily reverse changes that have already occurred. Importantly, the perceived efficacy did not vary significantly as a function of follow-up time, suggesting no discernible fading of effect over the 1- to 9-year follow-up period.


CONCLUSIONS: When performing cross-linking for keratoconus, we remove the thin outer layer of the cornea (the epithelium) to improve treatment penetration. Using a special imaging device, we found the epithelial thickness is often irregular in keratoconus and becomes more regular after the treatment - this can slightly mask the true treatment effect.
GLOBAL REACH

In addition to sharing research findings through print and online eye journals, we presented 37 talks to surgeons and leaders of industry across the globe.

**American Academy of Ophthalmology Annual Meeting**
**November 2017 - New Orleans, LA**
1. Comparison of 5-year graft survival and rejection episode rates with DMEK vs. DSEK. Price DA, Price MO, Feng MT, Price FW.
2. Prospective randomized study of riboflavin dosing frequency in corneal crosslinking for progressive keratoconus or ectasia. Price MO, Feng MT, Price FW.

**Cornea Day: AAO Meeting**
**November 2017 - New Orleans, LA**
The use of intraoperative OCT in anterior segment surgery. Price FW, Feng MT.

**Cornea Day: AAO Meeting**
**November 2017 - New Orleans, LA**
Comparison of 5-year graft survival and rejection episode rates with DMEK vs. DSEK. Price DA, Price MO, Feng MT, Price FW.

**American Society of Cataract & Refractive Surgery Meeting**
**April 2018 - Washington, DC**
1. Management considerations for the patient with Fuch’s dystrophy and cataract. Price FW.
2. Patient satisfaction with epithelium-off corneal crosslinking. Price MO, Price FW.
3. DMEK learning curve for a single surgeon without DSAEK experience: outcomes in first 500 consecutive cases. Feng MT, Price FW, Pabon S, Price MO.

**European Society of Cornea & Ocular Surface Disease Specialists**
**October 2017 - Lisbon, Portugal**
1. The use of intraoperative OCT in anterior segment surgery. Price FW.
2. Prospective randomized study of riboflavin dosing frequency in corneal crosslinking for progressive keratoconus or ectasia. Price MO, Price FW.
3. Immunologic rejection after DALK: incidence and risk factors. Price MO, Price FW.

**European Society of Cataract and Refractive Surgery Annual Meeting**
**October 2017 - Lisbon, Portugal**
1. DMEK trifolde technique: fact or fiction – does it aid in unfolding and reduce cell loss? Price FW, Price MO.

**Innovative Ocular Institute for Cornea Considerations in Cataract Surgery**
**November 2017 - Hyderabad, IN**
Cornea considerations in cataract surgery. Price MO.

**Refining Endothelial Keratoplasty Symposium**
**November 2017 - Bangkok, TH**
1. My surgical pearls for DSEK. Price FW.
2. Learning DMEK Pearls part 1 (graft preparation and injectors). Price FW.
3. Learning DMEK Pearls part 2 (Descemetorhexis, graft injection, orientation, centering and unfolding). Price FW.
4. Early post-op management (pupillary block, glaucoma, rebubbling). Price FW.
5. Combined cataract (triple) EK or sequential EK – why and how? Price FW.
6. EK in complex cases. Price FW.
7. EK complications & management. Price FW.
8. Why EK? The evidence and global status. Price MO.
9. Cornea donors for EK and factors determining EK graft survival. Price MO.
10. EK and glaucoma, what are the concerns? Price MO.

**L. V. Prasad Eye Institute Interactive Program**
**November 2017 - Hyderabad, IN**
1. OCT in corneal and anterior segment surgery. Price FW.
2. Basic technique of DMEK. Price FW.
3. Graft insertion methods, un wrapping and centration methods. Price FW.
4. Tips for a successful DMEK in various situations. Price FW.
5. DMEK complications. Price FW.
7. Update on keratoplasty survival. Price MO.

**Royal College of Ophthalmologists of Thailand Academic Meeting**
**November 2017 - Bangkok, TH**
Price FW. EK: new frontier in keratoplasty.

**Our Mission:** “To give people the opportunity for the best possible vision by innovating solutions for vision impairment and sharing results through relevant educational channels to reach a global audience. We expand possibilities and enrich lives by optimizing sight.”
Each gift helps pave the way for new and innovative treatments to help those in the coming years to have better visual outcomes when faced with complicated eye diseases like Fuchs’ dystrophy.

Thank you for every gift that helps make these advancements possible.

Founders
Gifts of $25,000+
David Glass
Geraldine La Motta
Joseph M. & Barbara Cohen Foundation, Inc.

Humanitarians
Gifts of $10,000-$24,999
Bill and Janet Grube
Gaugham Family Foundation
George and Susan Loesel
Lawrence McKinzie
Mead Johnson Nutrition
VisionFirst: Indiana Lions Eye and Tissue Bank

Patrons
Gifts of $5,000-$9,999
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Charlotte Bess
Homewood Suites - Indianapolis at the Crossing
John and Cynthia Mcroskey
Phyllis Nevil
Robert and Cynthia Grimm

Benefactors
Gifts of $2,500-$4,999
Charles Stewart Mott Foundation
Dr. and Mrs. Stephen Rosenfield
Fidelity Brokerage Service LLC
Jill S. Moller
John and Mary Byrnes
Kenneth Anderson
Kenneth Swedo
Peter Lang
Price Vision Group
The Neff Family Charitable Fund

Fellows
Gifts of $1,000-$2,499
Alfred and Carol Wick
Amy G. Poster
Anne Sims
Anonymous (3)
Beth and Wayne Lynn
Betsy and William Feinberg
Bill and Rosemary Stumbo
BMO Harris Bank
Bob and Diann Barnett
Carol and Tom Woodring
Donald Hutchinson
Estelle Mathers
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Harold and Joy Campbell
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Joseph Benitez Jr., MD
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Laura and Steve Lanuti / Motown Property Management
Lenore Anderson Endowment Leo Dapril
Lynn and Marsha Mitchell
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Norwood A. Whitfield
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Phillip-Van Huesen Corporation
Richard Michael Bassett
Ruth G. Blum
Stephen Salay
The Charles M. Uhl, Jr., and Teresa D. Uhl Family Foundation
The Mary and John C. McLimans Charitable Fund
The O'Connor-Campion Family Charitable Fund
UPS
Walter and Janet Gross

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Gifts of $500-$999
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Bob Jarosinski
Caby Byrne
Carol Bogosian
David Kendall, MD
Donald and Kathleen Smith
Donna Judge
Frances MacAllister
Holiday Inn Indianapolis
Jack and Gaye Schwarz
Jack and Patty Runyan
James and Danielle Buchanan
John F. Hanafee, Jr.
John Keane
Jorge Alberto Villa, Mr.
Joseph and Deborah DeRanieri
Kay E. Donaldson
Kent Alder
Lowell and Linda May
Mark and Janet Ott
May Chambers
MFTC, INC.
Michael Lapota
Michael Mullen
Michael Schwenteman
Norman Horstmann
Patricia A. Morril
Richard D. Kibby
Richard Wood
Robert Bundy
Roger Reichmuth
Terry Coyle
The UPS Foundation, Inc.
Thomas A. Musson
Tommy and Bonita Chandler
Vern Rensig
William Lawless

Friends
Gifts of $250-$499
Alan and Jean Frisoni
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Art and Cathy Mouton
Barbara J. Chaplin
Betty Neff
Billy and Ruth Price
CliftonLarsonAllen
David & Susan Slagle
David and Barbara Poe
David and Robin Felkins
Edita Masters
Francine K. Neal
Gayle S. Maffeo
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Jay and Mary Schwartz
Jeffrey & Laurie Potrzebowski
Jim and Marti Fickinger
Joan Walden
Joe and Beverly Kack
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John Frey
Keith and Nancy Alexander
Kenneth and Deborah Frazier
KG Landscape Design, LLC/Katia Goffin
Kristina Engineering Roach
Kurt and Joyce Moser
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Ralph Power
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Terry Ford
Thomas Foster
William J. Conley, Jr.
William Wendling
William Wheeler

“Having my vision restored after missing out on so many milestones in my family has truly been a blessing. My only regret is that I didn’t have the surgery sooner. I look forward to meeting my new granddaughter later this year with new eyes!”
- Susan, two DMEK cornea transplants

*If you have found an error in this listing or would prefer to be recognized in a different way, please email jessica@cornea.org. Thank you!*
SPECIAL EVENTS

Focus on Education OD Seminar
Our annual Optometry Seminar on November 18, 2017 provided 7 hours of continuing education credit to nearly 200 Midwest optometrists. As the first point of contact in eye care, optometrists must be versed in general eye care as well as the ability to identify complex eye problems and refer to specialists. Focus on Education identifies gaps in care and works to alleviate those gaps by providing relevant, up-to-date information to providers.

Cornea Classic Golf Fundraiser
Our annual Cornea Classic Golf Outing was held in June 2018 at Ironwood Golf Course in Fishers, Indiana. We hosted 30 foursomes and raised over $50,000 for vision research! Thanks to everyone who sponsored, volunteered or participated in the event. Next year, we look forward to a new venue at Prairie View Golf Club in Carmel, Indiana. Save the date for June 18, 2019!
ANNUAL REPORT
2017/18

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Indianapolis, IN 46260
Email: info@cornea.org
Phone: 317-814-2993
Fax: 317-814-2806
Web: Cornea.org

Thank you for reviewing our 2018 Annual Report. We appreciate your support and interest in cornea research.

Please visit us online at Cornea.org.

“That all who look may see.” ®