Eyelid taping may offer temporary alternative to blepharoplasty

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Eyelid taping may offer temporary alternative to blepharoplasty

By Katherine Mastrota, OD

Blepharoplasty is a surgical procedure in which the eyelid skin, orbicularis oculi muscle, and orbital fat are excised, redraped, or sculpted to rejuvenate the aesthetic look of the patient along with correction of any functional abnormality.1 In fact, blepharoplasty is one of the most popular cosmetic procedures in the United States.2

As people age, changes to the lower eyelids and midface include pseudoherniated orbital fat, tear trough deformity, lid laxity, and dermatochalasis. Surgical repair often aims at treating redundant skin or orbital fat malposition.3

Dermatochalasis or sagging eyelids are a common condition with skin redundancy and lid atrophy of the upper eyelids. This is mostly caused by aging. The overall prevalence of sagging eyelids among individuals

Eyelid taping is an alternative treatment to blepharoplasty. It involves the gentle application of tension to the eyelids, temporarily tightening and repositioning the skin. This can be beneficial for individuals who are not ready for surgery or prefer a non-invasive approach. The effects of eyelid taping are temporary and may last for a few days to a few weeks.

Use MIGS prior to late-stage glaucoma

By Marc Bloomenstein

In the past, some doctors have used an arms-length approach for glaucoma management. Measuring intraocular pressure (IOP) and evaluating the optic nerve for overt signs of damage or anything out of the ordinary is an essential part of any comprehensive eye exam.

Likewise, so is the diagnosis and management of lenticular changes that we call cataracts. The most common practical approach to managing our glaucoma patients was to lower IOP via topical medication and to provide better vision for our cataract patients.

Although there had been no changes in the type or modality of contact lens worn successfully for over a decade, her best corrected visual acuity fluctuated at 20/25 in both eyes with minimal improvement after removing her monthly contact lenses and instilling artificial tears.

Upon slit lamp examination, noted in both eyes were corneal chaffing and inflammation. There was no evidence of any other conditions that could explain her symptoms.

By Jade Coats, OD

29-year-old female presented for new glasses with a secondary complaint of recent intermittent blur at all distances with and without contact lenses. She reported that her contact lenses have been excessively moving and that her vision seems best immediately after blinking.

Although there had been no changes in the type or modality of contact lens worn successfully for over a decade, her best corrected visual acuity fluctuated at 20/25 in both eyes with minimal improvement after removing her monthly contact lenses and instilling artificial tears.

Upon slit lamp examination, noted in both eyes were corneal chaffing and inflammation. There was no evidence of any other conditions that could explain her symptoms.
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¹ US industry data on file.

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Demand for optometry projected to grow

By Benjamin P. Casella, OD, FAAO
Chief Optometric Editor
Practices in Augusta, Ga., with his father in his grandfather’s practice
bp casella@gmail.com
706-267-2872

When I was in college, a friend of mine once halfheartedly scoffed at the notion that I wanted to go to optometry school. He claimed that optometry would be obsolete in the near future with advancements in technology leading to a decrease in the demand for primary eye care by primary eyecare doctors.

Because that conversation took place about two decades ago, I decided to check in with the Bureau of Labor and Statistics as a means to check the pulse of the profession.

Optometry slated to grow

As it turns out, the demand for doctors of optometry is expected to grow by 18 percent over the next decade or so. For perspective, the number for all “health diagnosing and treating practitioners” is 16 percent, with the projected change in employment for all occupations combined to be 7 percent over that same time period.

There is a two-fold reason for our relative optimistic job security outlook:

- Aging population
- Aging practitioners

On one side is the fact that more older doctors of optometry will be retiring over the next decade or so, and that will open up employment opportunities for younger ones to come in and assume care of their patients. On the other side is the fact that the patient population is also aging, and the need for eye care will grow along with the age of the average patient.

Put into perspective

To put that 18 percent figure into perspective, as of 2016 there were approximately 40,200 employed doctors of optometry in the U.S. in 2016. In 2026, that number is expected to grow to approximately 47,400 by the year 2026.

An expected growth in demand of 7,200 doctors of optometry over the next decade or so should come as a welcome piece of knowledge to the optometry student and student hopeful, and our schools and colleges of optometry have yet another reason to keep our profession as competitive and selective as it is. Our patients deserve nothing less.

As for my friend, I’m happy to say that after all these years he is a successful practicing doctor of optometry.

REFERENCES

The demand for doctors of optometry is expected to grow by 18 percent over the next decade or so.
Optometry Times blogs

Optometry Times offers weekly blogs from some of the leaders in the optometric profession. Haven’t read them yet? Here’s what you’re missing.

4 tips to determine if a study article is accurate

Determining article credibility can be difficult. Tracy Schroeder-Swartz, OD, MS, FAAO, gives her four tips to determine if a study follow-up article is fact or fiction.

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How to avoid misdiagnosing common and uncommon conditions as a student

Many common and uncommon diagnoses mimic each other. Third-year student Shelby May offers her advice to help students diagnose patients correctly the first time.

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Resveratrol may be key in AMD stroke patient treatments

Anti-inflammatory properties of resveratrol show promise in retinal disease

A choice was presented to the eyecare community with the publication of mortality data concerning combined stroke/age-related macular degeneration (AMD) patients. Eyecare practitioners now know that intravitreal anti-vascular endothelial growth factor injections (anti-VEGF) used in stroke victims, must be used with extreme care—especially in the immediate stroke aftermath.

The adjusted mortality in patients who received bevaciuzumab (Avastin, Genentech) within three months after stroke/transient ischemic attack (TIA) is significantly different than in patients not exposed to bevacizumab (OR = 6.92, 95 percent, CI 1.88-25.43, p < 0.01). That is nearly a seven times higher risk of death.¹

Dangers of overuse
The Comparison of AMD Treatments Trials (CATT) follow-up study provides the most complete up-to-date review of the long-term outcomes of treatment of neovascular AMD with anti-VEGF drugs.²

Approximately 40 percent of eyes receiving anti-VEGF therapy deteriorated into geographic atrophy in years two through five, with a higher percentage of enrolled eyes in regimented monthly treatments.³

When and if a blockage of a cerebral (or coronary) artery occurs, the cerebral (or cardiac) tissue is protected by prior resveratrol-activated preconditioning. This biological phenomenon is called “hormesis.”

By inducing hormesis, protective cellular internal antioxidant enzymes (glutathione, catalase, superoxide dismutase) are activated prior to a stroke (or heart attack), so when blood circulation is restored there will not be any resultant cardiac or heart muscle damage (called reperfusion injury).⁴ Resveratrol and other “red wine” molecules induce hormesis.⁴

Resveratrol shows promise
Resveratrol metabolites have recently been detected in the eye after oral administra-
tion, signifying its ability to cross protective barriers and reinforce its potential benefit to vision conditions beyond its well-known protective role against heart disease and cancer.⁵

Evidence is mounting on resveratrol’s side as its anti-inflammatory, antioxidative, and anti-aging activity via different molecular mechanisms that have been highlighted in animal models and in vitro retinal cells.⁶ Resveratrol is the ideal candidate nutrient for an AREDS 3 clinical trial.⁷

Longevinex is the only resveratrol product to have undergone toxicity testing. The manufacturer has spent 15 years publishing science and petitioning the FDA to fast-track its use in AMD.⁸,⁹

Post-AREDS II science also suggests a vulnerable fovea is protected by foveal targeting zeaxanthin isomers in higher doses than used in the AREDS II study. I have written about this other red nutrient derived from paprika, that reduces both the personal and economic anti-VEGF injection burden.⁸,¹⁰

The choice is yours
As other sophisticated imaging modalities become more welcomed by insurance companies looking to prevent bilateral disease and save money, the OD becomes the first-in-line eyecare provider in identifying retinal disease.

Imaging quiescent pre-diabetic foveal micro-aneurysms and subclinical AMD quiescent sub-retinal neovascularization, combined with preventative molecular nutritional medicine, is here.¹¹

REFERENCES

Dr. Richer is president of the Ocular Wellness and Nutrition Society. He is associate editor of Journal of the American College of Nutrition and associate professor of family and preventive medicine at Chicago Medical School. Dr. Richer is global scientific director of Zeaxanthin Trade Association, he receives research funding from ZeaVision, and he consults for Bausch + Lomb, Eyecheck, Douglas Labs, and Stereo Optical.
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References:

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older than 45 years is reported to be 16 percent and is more frequent in males.¹

**Blepharoplasty complications**

Many patients will seek blepharoplasty for cosmetic concerns related to dermatochalasis of the upper or lower eyelids.

A large amount of excess skin may contribute to physiologic pathology. Significant dermatochalasis of the upper lids may contribute to lateral hooding and visual obstruction. Upper and lower lid blepharoplasty both have their own set of indications, and the procedures may be undertaken simultaneously or at different times.

With blepharoplasty, common complications that can occur are lagophthalmos, ectropion, dry eyes, chemosis, granulomas, ptosis, scleral show, and retrobar hemorrhaging.²,6

Lagophthalmos and ectropion may occur from excessive skin excision or damage to the zygomatic nerve leading to a reduced orbicularis tone.

**Eyelid taping**

Many patients are exploring the option of eyelid taping to change the contour of the upper eyelid. Eyelid taping originated in Japan in the 1970s.⁷

This procedure was originally used to eliminate the monolid—where the eyelid does not have a crease at all—and create a double lid. Eyelid tape has now become popular in the United States to aesthetically and functionally target hooded lids.

Eyelid tape is applied to the upper eyelids to re-create the eyelid crease, thereby re-contouring it. The tape can be tailored in length, diameter, and placement to address just for any eyelid asymmetry. The tape can be removed and replaced as desired or if there is an allergy to the adhesives or products. Accident-related misdirection of instruments for application of the product around the eye area is of concern.

There are many options for eyelid taping. These options include:

- Single-sided taping strips
- Double-sided strips
- Eyelid laces and fibers
- An assortment of glues that can be used with or without the taping products

These products are available in strips and spoons in a variety of sizes and shapes, precut or not, and with or without applicator gadgets and eyelid manipulation instruments.

Eyelid glue—sometimes called eye putty—is an adhesive applied to the lid using a plastic prong-like device to push the skin up and adhere to the glue. This procedure changes or creates a crease.

**Eyelid taping options**

- Single-sided taping strips
- Double-sided strips
- Eyelid laces and fibers
- An assortment of glues that can be used with or without the taping products

**Taping may help**

It is unclear if frequent application and removal of eyelid tape or glue changes the elasticity of the delicate eyelid skin. In a personal experiment with lid taping (see Figures 1A and B), I have experienced mild, transient lid edema at the upper edge of the tape.

Should lid taping be a service offered in our offices as we approach aesthetic eye care in our practices? Can taping be a temporary method to avoid blepharoplasty in contraindicated cases? Can temporary eyelid tape application assist our patients in surgical decision making?

Asking these questions and keeping abreast of current social trends outside our sphere of expertise is interesting and can often impact our patient care.

**REFERENCES**


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Dr. Jessica Crooker notes, “Whenever fitting patients for contact lenses, I always recommend daily disposable lenses first. The DAILIES® Choice Program has allowed me to move many 2-week and monthly replacement contact lens wearers into DAILIES contact lenses because of the great value.”

Dr. Jeffrey Frank also uses the program to help get his patients into DAILIES® contact lenses: “DAILIES TOTAL1® is my go-to lens, and with the DAILIES® Choice program, it offers excellent value to my patients and practice.”

Dr. Douglas J. Bosner says, “My patients are able to enjoy the comfort and convenience benefits of DAILIES® AquaComfort Plus® and DAILIES TOTAL1® lenses at a price point that can rival and often beat the cost of 2-week or monthly replacement lenses.”

For Dr. Pamela Lowe’s practice, the DAILIES® Choice Program has helped to increase annual supply sales of DAILIES® lenses. Incorporating the DAILIES® Choice Program into her practice has been easy: “Patients handle the rebate themselves via the online portal, so there is no extra paperwork for my staff!”

Alcon is committed to improving access to its DAILIES TOTAL1® and DAILIES® AquaComfort Plus® contact lenses so that patients can experience the benefits of a daily disposable wearing schedule.2,3

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References
4. Alcon data on file, 2015
5. Alcon data on file, 2016

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via removal and replacement of the lens. With the advent of micro-invasive glaucoma surgery (MIGS), we can now bring the management of both together in one process.

**Qualifying patients for MIGS**
The decision to refer a patient for MIGS is a change for some clinicians who withheld the notion of surgery for the late stage of the disease. However, when just using topical therapy, it may be more challenging to obtain an optimal IOP target.

Structural damage and progressive field loss were once the sole benchmarks to advise a patient for surgical intervention. Now, with advancements in nerve fiber evaluation and scanning technology, an earlier intervention is advised.

**Overcoming obstacles**
When considering surgery, the lack of compliance—estimated from 25 percent to 80 percent—also needs to be taken into consideration. As the Ocular Hypertension Treatment Study (OHTS) determined, 39 percent of eyes required two or more drops to achieve a 20 percent IOP reduction from baseline.

Another hurdle for glaucoma management continues to be the economic burden on patients. Although new topical treatments are coming to the market, insurance barriers can become roadblocks to patients getting these medications covered under their insurances.

Drug cost is considered one of the leading roadblocks to topical adherence. Combining the lack of patients’ enthusiasm with drops and the addition of multiple therapies, their treatment goals may not be realized. In the case of non-compliance, a MIGS procedure can bring a patient’s IOP down to a monotherapy level or possibly eliminate the need to for topical treatment.

**Form an action plan**
Generally speaking, MIGS procedures are ab interno, microincisional, and conjunctival-sparing. They share a common approach of minimal tissue trauma and minimal disruption of the normal anatomy and physiology. MIGS may provide a solution for many challenges that face glaucoma patients. These challenges can include compliance, drop cost, and the ocular surface implications of glaucoma medications. The different devices lower IOP between 3.2 and 12.6 mm Hg; they are suited for mild to moderate glaucoma.

The reduction of IOP seems to be greater in patients with higher baseline IOP levels. The magnitude of the IOP-lowering effect seems to depend on the number of shunts or stents that are implanted. Besides the IOP-lowering effect, the surgeon may need to consider other parameters in deciding the best option for the patient.

The mode of action followed may be one criterion. The iStent (Glaukos Corporation) works by improving aqueous humor outflow at the Schlemm’s canal, whereas CyPass (Allcon) and iStent Supra (Glaukos Corporation) are generating new and outflow pathways into the suprachoroidal space or the subconjunctival space with Xen (Allergan).

ODs must consider bleb evaluation with the Xen procedure. Xen is a modern version of a traditional trabeculectomy. Xen reduces the side-effect profile that is accompanied with the traditional trabeculectomy. This is why an understanding of the pressure, bleb profile, and treatment options are necessary to manage these patients successfully.

**Safety profile and communication**
The safety profile of the different approaches should be considered—especially the risk for generating hypotony. Because of these considerations, surgeons may wish to use the Schlemm’s canal micro-stents in patients with mild to moderate glaucoma and the suprachoroidal and subconjunctival devices for the more severe cases of glaucoma.

It is important for the patient’s OD to engage in good communication with the cataract surgeon and glaucoma surgeon to determine which MIGS procedure will render the best outcome.

Managing a MIGS patient is very similar to managing a cataract patient. It is crucial to control the inflammation and the ocular surface for maintenance of good vision and healing. However, IOP management varies for each patient and procedure.

For example, the use of iStent may be a low risk of hypotony, whereas CyPass and Xen both have a higher risk of transient hypotony. Blood is involved in these latter procedures, and hyphemia and subconjunctival hemorrhaging may be a post-operative consideration.

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Why documenting target IOP helps ODs

Staying up to date, reaching targeted IOP important when treating patients

A good friend and colleague recently asked me whether I still documented target intraocular pressures (IOP) when treating glaucoma. My short answer was yes. Although there are numerous and various medical and surgical routes to achieve lower IOP, the overriding theme to treating glaucoma is a “point A to point B” approach.

Simply put: lowering IOP is still essentially the only thing ODs can do for glaucoma patients—and ODs still subscribe to landmark studies when doing so.

Lowering IOP still beneficial

One such study that I have quoted numerous times over the years during lectures has been the Collaborative Normal Tension Glaucoma Study (CNGTS). In this landmark longitudinal study, the investigators found that lowering IOP in patients was still beneficial even in the face of so-called “normal” baseline pressures.

The big number that came out of this study was 30 percent. One eye of eligible patients was randomized to a 30 percent IOP reduction or a control (no pressure reduction). Treatment was medical (with topical ocular hypotensive agents) or surgical (filtration surgery).

The endpoint results were measured as visual field preservation over a period of years. These results were adjusted to account for the effects of post-surgical cataracts in the surgical arm of the study. When this study took place, minimally invasive glaucoma surgeries (MIGS) did not exist.

However, when adjusted, these results pointed to the fact that the treated eyes had a 50 percent less chance of deteriorating visual fields over a five-year period than did the control eyes. Importantly and correctly, researchers made note of the fact that not all of the control eyes progressed. This prompted researchers to advise the clinician to take this into account when deciding on management of normal tension glaucoma patients on an individual basis.

Not all glaucoma patients are going to progress. Those patients who do will progress at different rates. In light of this notion, it may be beneficial in some cases to perform multiple diagnostic studies before the decision to treat or monitor the patient is made.

Lowering IOP is still essentially the only thing ODs can do for glaucoma patients

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tion superiorly, bilateral bulbar conjunctival injection, and moderate superficial punctate keratitis.

Additionally, there were numerous large papillae along the tarsal conjunctiva of the lower lids. Confirmed with lid eversion, it was clear that this patient was suffering from giant papillary conjunctivitis (GPC).

Corneal staining showed superficial punctate keratitis in both eyes at the first visit, which was more evident on the initial baseline tangential topography map. (See Figure 1.)

Un fortunately, GPC can be difficult to diagnose because patients with the condition can simultaneously exhibit other forms of allergy. Regardless, when a patient mentions chronic contact lens instability, it is an opportunity to dive deeper and re-evaluate contact lens modality and/or recommend discontinued use of contact lenses for a period.

GPC often occurs as a response to chronic, mechanical trauma that causes mast cells to be hyperactive and promote other immune cells to form small conjunctival papillae that coalesce into larger papillae.2

Often known as contact lens-induced papillary conjunctivitis, GPC has been associated with all types of contact lenses materials, including rigid, hydrogel, and silicone hydrogel.3

Complaints of excessive tearing, foreign body sensation, hyperemia, and contact lens instability are common signs and symptoms associated with GPC.

Unlike other allergy diagnoses, such as vernal keratoconjunctivitis (VKC) and atopic keratoconjunctivitis (AKC), GPC is not an allergic reaction, and the patient complaint of itching is generally absent.4 By understanding that GPC is an inflammatory condition caused by repeated mechanical irritation, optometrists can better identify and treat these patients.

It is important for optometrists to discuss patients that spectacle correction may offer a much-needed break from contact lens wear. As evidence shows, patients wearing a monthly contact lens had an increased rate of GPC, but switching to a more frequent contact lens replacement schedule decreased the incidence from 36 percent to 4.5 percent.5

**Topography shows detail**

Using topography to help identify and monitor ocular surface disease, optometrists can assess the cornea on a more detailed level to obtain a better understanding of the affected corneal areas.

Although both axial and tangential maps provide good data, tangential maps show more detailed information while axial maps display the average corneal changes.6

Often, a baseline topography scan reveals the missing puzzle piece to the final diagnosis. After all, GPC is estimated to affect 1 to 5 percent of the 12 million wearers of soft contact lenses in the United States and perhaps 1 percent of the 8 million wearers of rigid contact lenses.6

**GPC masquerade**

Technology can be useful to help diagnose corneal disease, but it is imperative to recognize that GPC can be masquerading as an allergic reaction, conjunctivitis, or as a pseudo-ectasia when assessed with a topographer. Furthermore, understanding that the underlying culprit of diagnosis and treatment of GPC is chronic inflammation secondary to mechanical trauma instead of an allergic process can help optometrists to be more efficient and accurate when managing the primary etiology.

**References**


Dr. Coats is a member of the American Optometric Association, the AOA Political Action Committee, Arkansas Optometric Association’s National Legislation Committee, and Women in Optometry. She is an advisor and speaker for Share cjadecoats2020@gmail.com

**TAKE-HOME MESSAGE** Giant papillary conjunctivitis is a mechanical irritation, and it can masquerade as other conditions such as an allergic reaction, conjunctivitis, or a pseudo-ectasia. Corneal topography can help differentiate the underlying cause. This case illustrates how contact lens instability leads to a diagnosis of GPC.
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REFERENCES: 1. In vitro studies evaluated the rate of release of sodium hyaluronate (HA), a conditioning agent in the Biotrue® multi-purpose solution, from both conventional and silicone hydrogel contact lenses over a twenty-hour time period. HA was adsorbed on all traditional and silicone hydrogel contact lenses tested upon soaking in the solution overnight. HA is then released from the lenses throughout at least a twenty-hour time period when rinsed with Hank’s balanced salt solution at a rate mimicking tear secretions. The in-vitro performance of Biotrue® multi-purpose solution suggests that it will provide lens conditioning throughout a twenty-hour time period. 2. Scheuer CA, Doty K, Liranso t, Burke SE. Wetting agent retention and release from hydrogel and silicone hydrogel contact lenses. Invest Ophthalmol Vis Sci 2011;52: ARVO E-Abstract 6487. Continuous release of wetting agent from the silicone hydrogel lenses was determined as the number of hours across which a consistent statistical decrease in ST could be detected for all silicone hydrogel lenses tested. 3. Data on file. Bausch & Lomb Incorporated. Rochester, NY.

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4 tips to help staff identify contact lens candidates

Finding new lens wearers should not be only the optometrist’s job

By Jim R. Hoffman, OD, FAAO

Finding new lens wearers should not be only the optometrist’s job. Consider incentivizing employees to help identify patients who may be good contact lens candidates.

1. **Involve all staff in contact lens education**
   Ensuring that all staff is knowledgeable in the latest contact lens technology is imperative in identifying and securing contact lens candidates and contact lens upgrades. In our practice, doctors and staff don’t assume that doing so is only one person’s job—it’s everyone’s job. Consider incentivizing staff members to learn more about contact lens advancements, which in turn will help them best meet the needs of the patients in the practice.

   One way to better meet the needs of the patients is to work with local sales reps to educate staff on the latest contact lens products and technology on the market.

   Our office hosts a complimentary breakfast staff meeting during which contact lens sales representatives discuss the latest lens technology. Our staff appreciates the invitation to join because they can learn about something new on the market while having the opportunity to ask representatives questions. By hosting these open meetings, sales reps can educate staff to understand what market needs new lens technologies are fulfilling, providing them with the necessary data to cater to all types of patient needs and lifestyles.

   Another route to involve your staff is providing hands-on training. This may help them feel even more comfortable when speaking about the product benefits with patients. Fit your staff with the latest in contact lens technology to provide them the opportunity to become clinically comfortable with the lenses and see how they perform.

   As an example, a contact lens manufacturer extended its product line with a toric lens design. Working with our sales representative, we organized an all-staff event to discuss the features and benefits of the latest toric lenses and the importance of having completed product portfolios. Following the session, a few staff members were fitted with the lens, and now the entire team feels confident in approaching patients about the possibility of wearing these contact lenses.

2. **Get to know patients and their lens wear habits**
   Taking the time to get to know patients and understanding their contact lens-wearing habits should be a priority for the entire staff, not just the doctor.

   This understanding begins when a patient first schedules his appointment. Arm your staff with prompts on how they can naturally weave in questions about patients’ glasses and contact lens-wearing habits. This communication may happen through email, over the phone, and at the office during the appointment itself.

   For example, if a patient schedules an appointment to update her contact lens prescription, the receptionist can share that the office has the latest in contact lens technology and that the doctor looks forward to discussing these lenses during the patient’s upcoming visit.

   If a patient is looking to update his glasses, our staff asks about his experience with contact lenses (or lack thereof) to share with the doctor prior to the appointment.

   For example, a staff member might say, “I see your appointment is specific to your current glasses prescription, and your records show that you have been dealing with presbyopia. Would you be interested in learning more from your doctor about innovative contact lens technology that is helping other patients with similar vision concerns see comfortably and clearly?”

   In addition, when patients arrive to the office for their appointments, staff should reignite the conversation around contact lenses without being pushy. This can happen by the staffer asking patients if they brought their glasses or contact lenses to the visit and referencing the phone conversation patients had previously with staff about trying new contact lens technology.

   Depending on a patient’s experience with contact lenses, staff can position the question as a potential solution for their visual correction. “I understand that glasses work for you, but many of our patients are wearing contact lenses to address their visual needs and rid themselves of the cumbersomeness of readers.”

   Once the patient arrives in the examination room with the optometrist, the contact lens conversation has been raised multiple times. Based on the information the rest of the staff could obtain, the optometrist can present innovation in contact lenses specifically for that patient, noting the reasons that particular lens provides benefit to their patient’s needs (e.g. lifestyle, visual correction, comfort, cost and convenience, and so on).
Streamline in-office promotional material
Surface clings, promotional videos and in-office educational material should reflect the contact lenses that your team is discussing with patients.

Remind staff that brochures on display should promote the innovative technology in contact lenses that the office prescribes. Staffers should freely distribute this material to patients who may be interested in contact lens wear or who are wearing older contact lens technology. Most contact lens manufacturers provide patient rebates, making the potential switch to contact lenses or upgraded materials a cost-effective win-win for the patient.

As a team, decide which contact lenses staff should help promote and make sure that promotional materials are consistent with this message.

Harness the power of the thank-you note
A patient’s experience after leaving the office is just as important as her time during her visit.

In addition to sending a “thank you” email expressing our staff’s appreciation to patients for visiting our office, our team continues the contact lens conversation with follow-up questions about the fit and comfort of their trial lenses.

This is an example:
“We’re so glad that you decided to experience [company and brand name] astigmatic contact lenses. We would love to hear how your experience with the contact lens is going so far. Do you notice you are able to wear the lens comfortably throughout the day? Has this helped reduce halos and glare while driving at night? If you have any questions about the contact lens, we would be happy to schedule a time for you to speak with a staff member.”

Our team will also follow up with a phone call to patients to answer questions they have about the lenses and to schedule their next annual exam. Through this continuous contact with patients, we not only help their transition to a new contact lens go smoothly, but also we reinforce that our team is here to provide them with support to ensure they obtain the best vision possible.

Making it happen
As optometrists begin to train and educate their staffs on the importance of how they communicate with potential contact lens patients, remind them of these three tips:

- Everyone in the office plays a part in optimizing the patient experience.
- Understanding the patient’s needs and prescribing innovative technology will go a long way to meet the patient’s needs.
- It should be the common goal to ensure that patients leave the office thinking how the whole team helped them to have a higher quality experience.

Dr. Hoffman has been a partner at his private practice for 29 years, concentrating on contact lenses and pediatrics. He is a member of the American Optometric Association, Florida Optometric Association, and Northeast Florida Optometric Society. Dr. Hoffman serves as a consultant for Bausch + Lomb and Allergan.

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Go to either website and select “Request Sample”
3 tips to upgrading astigmatic contact lens wearers

New technology can provide better vision to patients needing toric fits

By Jason R. Miller, OD, MBA

New technology looks great and is exciting to touch, feel, and experiment with. Unfortunately, many optometrists routinely forget about new technology and fall back into our comfort zone with contact lens fits.

Consider taking a step back to look at how you are attacking astigmatic contact lens situations. You may find there is a better way of doing things.

Patient education first

Many patients do not have a solid understanding of astigmatism. Some patients even associate the word with a disease state.

When talking with patients, do not assume they understand astigmatism—explain that astigmatism is simply a different way of focusing images. Educate your contact lens patients that having astigmatism requires them to utilize contact lenses designed to meet their visual needs.

Our astigmatic patients often receive spherical equivalent lenses prescribed in order to mask their cylinder. This practice began back in an era when not many toric lens options were available, and those options were not stable on the human eye. Uncorrected astigmatism results in distorted or blurred vision and a loss in “sharpness” of visual acuity. This can lead to headaches and eye fatigue.

Fortunately, we work in a different contact lens era with better material and design technology. For astigmatic patients previously wearing a spherical lens, consider upgrading them to a toric contact lens.

Following are three tips to help.

**STEP 1** Minimize masking

When patients are judging the care we provide, they do so based on how well they see with their vision correction, whether it is eyeglasses or contact lenses.

**TAKE-HOME MESSAGE** If you have astigmatic patients wearing spherical contact lenses, consider these three tips to upgrade them to toric lenses. Minimize masking, remember that toric parameters have grown exponentially, and don’t forget about enhanced comfort.
trated with the fitting process.

Due to the success of today’s toric contact lens designs, there is no longer a good reason to mask astigmatism. Masking cylinder with spherical contact lenses does not allow for the best visual outcome.

If there is any doubt with those 0.75 D cylinder patients, demonstrate the cylinder correction in the phoropter and ask which the patient prefers to have in his contact lenses. Additionally, demonstrate the cylinder axis. Explain that this contact lens has variable powers that have to be perfectly lined up in order to provide the best vision possible.

**STEP** Remember toric contact lens parameter options have grown exponentially

ODs can grow new contact lens wearers because many astigmatic patients have been told contact lenses are not an option for them. I’m not sure why some doctors are still spreading that rumor.

Contact lens options in multiple modalities are available for just about everyone.

**Due to the success of today’s toric contact lens designs, there is no longer a good reason to mask astigmatism**

Proactive contact lens practitioners realize that.

New materials and modalities may provide improved ocular health and convenience. Your patients need to be aware of this. Silicone hydrogel toric lenses offer improved oxygen permeability, and daily disposable toric lenses offer a viable option for part-time and full-time wearers looking for better convenience.

By offering patients an option that may not have been presented to them in the past, forward-thinking practitioners will tap into a new market of contact lens wearers.

Some astigmatic patients have failed with contact lenses in the past or are just not seeing as well as they could be and are skeptical to try something else. These patients may have experienced variable vision due to an unstable lens, too much lens rotation, or the specific contact lens parameters were not available.

These patients need to know that many new contact lenses options could potentially satisfy the visual and comfort requirements necessary to make them happy.

Discuss with patients how toric contact lenses come in specific prescription ranges and the fitting process helps ensure their astigmatism power and axis (already demonstrated behind the phoropter) are lined up perfectly for their vision. Such a discussion helps set the stage for patients to understand their contact lens prescription may be a little different if compared to their spectacle correction but is customized for their eyes.

**STEP** Don’t forget about enhanced comfort

With many patients spending their workdays in front of a computer, dry eyes at the end of the day due to digital eye fatigue is a growing concern. ODs can help address this challenge.

Start by asking your patients how many hours they spend each day in front of the computer. Next, ask them when their contact lenses begin to dry out and/or their vision becomes unstable.

Discomfort and blurred vision usually start midday. Increasingly, all patients (from kids to adults) are spending more time in front of a screen, and contact lens-related comfort must be addressed at every visit.

Opening the door to a conversation of computer or digital device usage enables optometrists to discuss options like daily disposables contact lenses and silicone hydrogel materials.

I tell patients, “We have new, improved contact lens options, and these lenses remain moist, allow more oxygen to your eyes, and can improve your end-of-day comfort, especially if you are spending more and more time in front of a computer screen.”

Additionally, all contact lens brands are not created equal in that all vary in their modulus, oxygen permeability, and edge design. All of those factors, along with the patient’s ocular health and environment, go into the patient’s perception of comfort with contact lens wear.

**Help your toric patients**

Helping astigmatic patients see more clearly can an exciting part of fitting contact lenses. There is significant value to the patient and to the practice in correcting low astigmatic patients. We may be able to eliminate many patient concerns by correcting even low amounts of astigmatism.

Use cylinder power and axis demonstrations to enhance the toric fitting process. Such demonstration further illustrates your abilities and helps patients understand the importance of stability in their contact lenses and the value of your contact lens fitting.

Improved toric contact lens designs allow your office to provide a differentiated product. Give your patient the option to see more clearly.
Peroxide lens care effective for GP lens wearers

This lens care option isn’t limited to soft contact lenses only

By Clark Y. Chang, MSA, MSc, OD, FAAO

Rigid gas permeable (GP) contact lenses continue to serve as essential tools for many patients. Besides providing exceptional optics, GP lenses offer durability, high oxygen transmissibility, and additional ocular surface health benefits, all of which can make them excellent options for patients with a wide range of visual and clinical needs.

Due to the availability of extensive lens designs and customization features, GP lenses provide an opportunity for advanced and individualized treatment applications.

GP lens designs include scleral GP lenses that offer optical rehabilitation in those with corneal irregularities or therapeutic protection in patients suffering from dry eyes.

Corneal GP lenses can be utilized for myopia control in the form of overnight wear of orthokeratology lenses.

GP lenses are typically the preferred clinical treatment tool for patients requiring vision correction after corneal and keratorefractive surgeries.

While generally less widespread than soft contact lenses at the present, global data suggest increasing clinical utilization of GP lenses, including scleral and orthokeratology lenses specifically.

**H2O2 advantages**

An important part of prescribing any non-single-use contact lens is making the right lens care recommendation. Hydrogen peroxide (H\(_2\)O\(_2\)) lens care systems have a history of safe, effective use, and have features that differentiate them from other systems often used for GP lenses (Figure 1).

First, H\(_2\)O\(_2\) has a mechanism of disinfection that differs from that of the biocides in the formulations of other lens care systems. In addition to meeting International Organization for Standardization (ISO) disinfection efficacy standards against free-floating bacteria and fungi,

H\(_2\)O\(_2\)'s mechanism of action allows it to effectively remove *Acanthamoeba* cysts and trophozoites, as well as bacterial and fungal biofilms.

Biofilms can form on the lens surface or inside lens cases. While they are typically more resistant to disinfectants than planktonic microorganisms, studies suggest that H\(_2\)O\(_2\) can more effectively remove biofilms than multipurpose solutions (MPS).

Second, H\(_2\)O\(_2\) lens care systems are preservative-free, which enhances their biocompatibility with the ocular surface. Preservatives contained in MPS and other GP lens care systems can be transferred onto the eyes at lens application and during lens wear.

The introduced preservatives can act as irritants, capable of altering corneal epithelial barrier integrity, which may be observed as diffuse punctate corneal staining and may negatively affect lens-wearing comfort.

Due to the lack of added preservatives, corneal staining is essentially absent with H\(_2\)O\(_2\) lens care use.

Available systems safely neutralize H\(_2\)O\(_2\) to concentrations that are well below human detection thresholds and are rapidly metabolized at the surface of the eye.

Finally, today’s one-step H\(_2\)O\(_2\) lens care systems support ease of use, which promotes better lens care compliance.

**H2O2 benefits GP lenses**

Many specialized features of H\(_2\)O\(_2\) lens care systems can have benefits for GP lens wearers, as well as wearers of hybrid lenses (which combine a central GP zone with a peripheral skirt made of a soft lens (SCL) material).

Lenses composed of GP materials are replaced less frequently than SCL disposable modalities. The clinical implication of this is that GP lenses can be exposed to higher cumulative levels of external irritants and microbial flora. Hence, the disinfection potency and biocompatibility of the recommended lens care system is crucial, and the disinfection efficacy of H\(_2\)O\(_2\) lens care systems can help support proper lens hygiene over the prescribed life span of each lens.

Today’s one-step H\(_2\)O\(_2\) systems can support effective disinfection by simplifying the lens care process. These systems combine disinfection and neutralization into a single step and do not require that lenses be rubbed prior to disinfection and neutralization, therefore making compliant lens care easier for patients. (Note that some patients will still benefit from being instructed to incorporate digital rubbing into their daily cleaning regimen.)

Lens case design allows patients to visualize the disinfection and neutralization process, which has the dual benefits of preventing patients from wearing their lenses before neutralization is complete and helping to promote timely case replacement.

**Figure 1.** A scleral contact lens (with NaFl) on an eye with a corneal graft. Photo courtesy Clark Y. Chang, MSA, MSc, OD, FAAO

**Figure 2.** A healthy cornea fitted with an aspheric gas permeable contact lens. Photo courtesy Ardie van Gojinga and Karin Teuben, Lens B.V.
Benefits to GP wearers

The preservative-free nature of H2O2 lens care offers important benefits to GP lens wearers. Like with any patient, the eyes of wearers of GP and hybrid lenses may be sensitive to potential effects of added preservatives, so efforts to avoid preservative exposure, when possible, can be beneficial. This can be particularly pertinent for wearers of specific specialty GP lens designs.

Wearing scleral GP lenses, which cover a large proportion of the ocular surface, or orthokeratology lenses, which are worn overnight, can limit tear exchange. If using a non-H2O2 lens care system with these types of lenses, the reduced replenishment of tears between the contact lens and the surface of the eye can potentially prolong the exposure time of ocular tissues to irritating preservatives.

In these and other clinical scenarios, practitioners can help limit patients’ preservative-related ocular burden and support a successful lens-wearing experience by recommending H2O2 lens care. It is encouraging that a recent survey of eyecare practitioners found that H2O2 was the most commonly prescribed type of lens care system for scleral lens disinfection.

REFERENCES


Dr. Chang is a subinvestigator in numerous clinical trials. He is immediate past president of New Jersey Academy of Optometry, and an advisory board member for International Keratoconus Academy for Eye Care Professionals (IKA), Gas Permeable Lens Institute (GPLI), and Optometric Cornea Cataract, and Refractive Society (OCCRS).
In the last 10 years, the disparity between the percentage of patients wearing astigmatic correction in their glasses vs. their contact lenses has been nearly eliminated.1-4 Today, roughly 40 percent of patients are wearing astigmatic correction in their spectacles, and about 30 percent of contact lens wearers are wearing astigmatic correction.5-7 The majority of the remaining 10 percent have low levels of cylinder less than 0.50 D to 0.75 D of cylinder and do not experience significant visual decline.8,9 These statistics are a testament to the many and varied outstanding toric options available to improve vision and the advances in fitting techniques which optimize chair time.

- Masking cylinder has been shown to be ineffective.10
- Aspheric lenses do not improve vision.11
- Empirically ordering both gas permeable (GP) and soft torics is highly successful even in patients with moderate to high astigmatism.12
- Orthokeratology is now available in toric for patients with moderate cylinder.13
- Hybrid lenses are also effective in the correction of regular astigmatism.14
- Scleral lenses for the normal cornea provide yet another option for those patients with significant astigmatism.15

Table 1 demonstrates the diverse options now available for astigmatism correction in contact lenses.

**Options for the low astigmat**

Patients with cylinder between -0.75 D and -1.75 D are easily fit with daily or traditional multipackaged soft contact lenses16,17 in an extremely wide range of spherical power. The lenses are highly successful, and newer designs provide extremely stable fitting and vision.18 A recent study showed that patients wearing toric contact lenses had a better quality of life than patients who wore spherical lenses as determined by the NEI-RQL-42 survey.19 This study supported previous works that indicated nearly 92 percent of patients with a toric correction preferred their vision when they were fully corrected.20

Young children (ages 4-10 years) with toric correction adapt extremely well to rigid modalities.20 Young patients with low to moderate myopic astigmatic prescriptions can easily be corrected with orthokeratology (ortho-k), which provides the benefit of full correction of their prescriptions and myopia control. For hyperopic astigmatism and those with higher amounts of myopia, spherical corneal GPs remain an outstanding option. The smaller overall diameter of corneal GPs can facilitate successful application and removal training due to the patient’s small eye. In addition, these lenses can be ordered empirically, allowing children to experience outstanding vision with their very first contact lens experience. Cost in these situations for spherical GP lenses on mildly toric corneas with mild to moderate refractive cylinder is significantly less in cost of goods.

GPs remain an outstanding vision correction option due to the precise optical quality generated.

For slightly older children, ortho-k may remain an outstanding option; however, cost and desire for disposability are attractive features of soft torics. Orthokeratology may also provide an alternative in adults who struggle with contact-lens-induced dry eye.

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**TAKE-HOME MESSAGE**

Patients with astigmatism have different needs, and fitting such patients with contact lenses best suited them can address those needs. Consider soft torics, GP torics, toric ortho-k, and scleral lenses, as these cases illustrate.
For most adults and teens, daily disposables and multipackaged lenses dominate the lens selections with their expansive array of parameters, outstanding comfort, and convenience.

Options for the moderate-to-high astigmat

Soft toric lenses have been shown to be successful in low, moderate, and high astigmatism.17,18 With expanded parameters of daily disposable lenses ranging from -0.75 D to -2.25 D, very few patients have prescriptions outside of what is currently available. Multipackaged lenses expand the available parameters to -2.75 D cylinder. The latest designs offer multiple stabilization zones resulting in a lens that remains rotationally stable in primary as well as extreme gazes.

Toric ortho-k lenses are emerging in most marketplaces. These modified designs provide on average -2.50 DC correction while also offering myopia control for those with higher amounts of compound myopic astigmatism.13 When corneal cylinder exceeds -2.50 D, back-surface toric GPs become an outstanding option. Fitting them empirically is straightforward, efficient, and extremely successful.12

For smaller corneas, the saddle method of fitting the cornea 0.50 D steep in the flat meridian and 0.50 D flat in the steep meridian is highly effective.

For average and large corneas, the Mandell-Moore method of fitting the flat meridian 0.25 D flat and the steep meridian flatter than K on a sliding scale as the cylinder increases is equally successful. Find an online calculator tool at http://www.gpli.info/mandell-moore/ to aid in designing your initial bitoric lenses.

These patients achieve excellent vision which may be superior to that of soft lenses. In fact, a study by Michaud showed that 4/10 current soft toric lens wearers chose to wear toric GPs for improved vision.12 This dispels the myth that a previous soft lens wearer will not adapt to corneal GPs.

When patients have struggled with standard multipackaged soft lenses and GP options, it may be time to consider custom soft lenses, hybrids, and scleral lenses. Some patients with atypical corneal diameters may experience more stable fitting and vision with a custom soft lens with a custom diameter. Additionally, new designs offer lens powers that are nearly limitless in sphere and extend to -10.00 D in cylinder.

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In addition, the development of scleral lenses for the regular cornea offer virtually limitless power options and high-quality vision correction. Newer regular cornea scleral GPs are similar in size to soft lenses and can be designed with toric peripheries or haptics to stabilize lens rotation as well as front toric optics to correct any residual astigmatism for patients with high astigmatic corrections.15,21

There are now as many options for the as-

See Astigmatic patients on page 22

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Together we’ll go far
tigmatic patients as there are for the spherical patient.

Case 1
9-year-old female
The patient’s mother is very concerned about myopic progression in her daughter. The patient has increased from -2.75 D to -4.00 D in a year. However, she also has -2.25 D cylinder.

After discussing options of soft toric, GP or ortho-k, the parent opted for ortho-k for multiple reasons, including myopia control, gymnastics, and swimming. The parent strongly preferred no lens wear for sports. Topographies were sent electronically to the manufacturer along with spectacle prescription, and lenses with enhanced toric peripheries were designed. Spherical ortho-k lenses were ordered empirically.

SRx:
OD: -4.00-2.25 x 007; 20/20; SimKs 42.05/44.13
OS: -3.00-2.25 x 178; 20/20; SimKs 41.88/44.08

See Figures 1 and 2.
The lenses provided very centered treatment zones. See Figures 3 and 4.
At one year, the vision remained 20/25 unaided with a -0.25 DS refraction to 20/20 in each eye. See Figures 5 and 6 for post-treatment topographies.

Case 2
12-year-old male
The child has broken multiple pairs of glasses and refuses to wear them. His mother is concerned that he will lose contact lenses and wants him to have something disposable so he will have spares.

SRx:
OD: +2.75-2.75 x 020; 20/40; SimKs 43.20/46.25
OS: +2.75-4.25 x 160; 20/40; Sim Ks 42.47/46.21

See Figure 7 for topographies.
I prescribed custom soft toric monthly replacement contact lenses.
OD: +3.25-3.25 x 010; 8.7 mm base curve; 14.5 mm diameter; 20/25
OS: +3.00-3.75 x 165; 8.7 mm base curve; 14.5 mm diameter; 20/30

The patient very successful with application and removal. At the six-month follow-up visit, his parent reports improved academic success.
Case 3
8-year-old female

Parents report that the patient does not wear her spectacles, and they would like her to try contact lenses.

SRx:
OD: +0.50-2.50x010; 20/20; SimKs 41.03/43.07
OS: +1.25-2.75x163; 20/30; SimKs 40.44/43.50

Bitoric GPs were designed using a saddle technique and ordered based on an over-refraction on Pl/-3.00; 41.00/43.00; 9.2 mm diagnostic lenses.

Final lenses were:
OD: -0.25/-2.25; 41.00/43.00; 9.0 mm; 20/20
OS: -0.50/-2.50; 41.00/43.00; 9.0 mm; 20/25

The child and parents were successful with application and

See Astigmatic patients on page 24

Figures 5 and 6. Post treatment topographies.

Figure 7 OD and OS topographies showing high regular astigmatism.
Astigmatic patients

Continued from page 23

removal. The patient wore lenses for school with good success.

Case 4
8-year-old female

This patient was referred from the pediatrics department for a contact lens fitting. Pediatrics' goals were to maximize her vision so she will be more successful with vision therapy for an intermittent left exotropia.

SRx:
OD: -1.75-6.50 x 005; 20/30; Manual Ks 41.75/46.75
OS: -1.00-8.50 x 180; 20/50; Manual Ks 40.75/47.75

Initially she was fit with bitoric corneal GPs which provided excellent vision; however, she struggled with redness and irritation.

Initial bitoric corneal GPs:
OD: -2.00/-6.00; 41.50/45.75; 8.8 mm; 20/25
OS: -2.00/-6.00; 41.50/46.75; 8.8 mm; 20/40

Unfortunately, upon follow-up, the lenses became adherent (See Figure 12). Therefore, she was refit into scleral lenses. Her staining resolved, and she was able to wear the sclerals throughout the school day.

Final scleral GPs:
OD: -5.50; 7.40 mm; 14.3 mm flat edge; 20/25
OS: -4.50; 7.40 mm; 14.3 mm flat edge; 20/25

After vision therapy and a year in the sclerals, best corrected vision improved to 20/20 and 20/25, and her left eye no longer tropes.

Case 5
36-year-old male

The patient presents to the clinic with a desire to improve his vision in his left eye. He is currently wearing spectacles:
OD: -0.50-2.50 x 180; 20/20
OS: +2.00-4.00 x 180; 20/200

Updated refraction:
OD: -1.50-2.50 x 180; 20/20; SimKs 40.00/43.10
OS: -1.75-6.50 x 175; 20/30; SimKs 40.70/45.30

Cycloplegic evaluation revealed a left prescription of +6.00-7.50 x 170. However, with the full prescription, the patient experienced diplopia at near and OS suppression at distance. Therefore, he was fit with bitoric lenses in hopes of improving his vision, equalizing image size and eliminating diplopia (see Figures 13 and 14).

An initial pair of diagnostic lenses were applied based upon Mandell-Moore, and after over-refraction the following corneal GPs were ordered:

OD: -0.75/-2.25; 41.00/43.00; 9.2 mm; 20/20
OS: +5.50 back toric; 39.50/44.75; 9.2 mm; 20/25

The diplopia resolved with the new lenses, and the patient reported increased driving confidence, especially at night.

Conclusion

All of these patients experienced vision improvement when they were fit with contact lenses to correct their astigmatism. Based on the patient’s needs, each needed a different type of lens.

For myopia control, toric ortho-k was helpful for Case 1. For his active lifestyle, soft torics provided a better option for Case 2. For Case 3, a scleral was needed to provide appropriate ocular health and vision correction. And for Cases 4 and 5, GP torics optimized vision.

We can easily dispell the myth, “I can’t wear contact lenses because I have astigmatism.” Today’s lenses offer high quality visual options with excellent comfort and efficient empirical fitting.

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Dr. Reeder is course master for the specialty contact lens, microbiology, and anterior segment disease courses; the educational technology committee chair; and the coordinator for the ocular disease curriculum. She is a Diplomate in the Cornea and Contact Lens Section of the American Academy of Optometry. She is an active Lions Club member and currently serves District 1-J Lions as a Zone Chair and the District chairperson for Sight preservation, Awareness and Action. rreeder@ico.edu.
Evatik releases new men’s frames for its Summer collection

PLATTSBURGH, NY—Evatik has released two new styles for its men’s Summer collection. Both frames come in three different color combinations.

E-9169 features a flat metal front, matte finish, and contrasting colorations of brown forest, black red, and grey cobalt. Temples are etched with a herringbone pattern for a textured look.

E-9170 has a horn-patterned acetate that features contrasting finishes. The woodgrain finish on the top front of the frame and the temples accentuates the high-gloss finish on the bottom front. This large-fit frame is available in color combinations of olive wood, brown wood, and black wood.

La Matta releases new women’s styles for Summer 2018

MILAN, ITALY—Animal prints are still the main theme of La Matta’s core models. La Matta, Area98’s womenswear brand, unveils its new models for its core collection and capsule collection for spring/summer 2018.

LM3222 has a boxy frame front and plays on the contrast of two-tone acetates, while the hinges of the temples feature nuggets of acetate.

LM3231 is a wider, slightly cat-eye design. It features a three-dimensional glazed metal insert with three small contrasting inserts.

La Matta capsule collection has been enhanced with four eyeglasses models: LM3232, LM3233, LM3234, and LM3235. The new products display patterns in which cheetahs or coral snakes are combined with floral motifs which are exhibited along the brows and the temples.
Dry eye is one of the most frequent causes of patients visiting eye care practitioners, affecting an estimated 30 million people in the U.S.1 As many as 1 in 3 ophthalmic patients report experiencing at least one symptom of dry eye.2 Yet this condition may be missed by eye care providers, in part because of the wide variability in its clinical presentation. Not all patients present with the classic symptoms such as irritation and burning. Many may seek help for what they describe as fluctuating vision, eye fatigue, among other atypical symptoms.3

In addition to prompt recognition, an understanding of the mechanisms leading to dry eye is key to its management. In July 2017, the Tear Film and Ocular Surface Society published the second Dry Eye Workshop (DEWS II) findings which emphasize that the tear film should be thought of as 2-layered, with a lipid layer overlying a mucous-aqueous phase.4 It is likely that interactions of the whole tear film, including lipids, mucins, proteins, and salts, maintain tear film homeostasis, and thus a lubricant that addresses all layers of the tear film is needed.4,5

Restoration of tear homeostasis is indeed the focus in the management of dry eye. In aqueous-deficient dry eye, lacrimal secretion is reduced. In evaporative dry eye, patients experience excessive evaporation from insufficient production of protective lipids as seen in cases of meibomian gland dysfunction (MGD).6

Dry eye is complex and can have a real impact on a patient’s quality of life.7 SYSTANE® Complete is designed to provide symptom relief for every major type of dry eye.8,9,10,11

References


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Dr Gupta was compensated by Alcon for her participation in this advertorial.

Preeya K. Gupta, MD
Duke University Eye Center
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New SYSTANE® Complete
Seeks to Fill a Critical Need in Dry Eye Management

Dry eye can be seen in 30-70% of patients according to the DEWS II report.1 If only one of these dry eye types is addressed, patients may not be able to derive maximal relief.2 A simple way to help patients is to recommend a drop designed for all major types of dry eye, such as SYSTANE® Complete. This innovative formulation supplements all the layers of the tear film, which helps to restore the tear structure and protect from evaporation.3

SYSTANE® Complete is developed with advanced nano-droplet technology.4 The nano-droplet contains the lubricant propylene glycol, and phospholipid and mineral oil to help deliver the active ingredient. Lubricant is rapidly delivered across the ocular surface5 to provide fast hydration, locking in moisture for long-lasting relief.6

SYSTANE® Complete is designed to minimize blur on instillation due to its nano-droplet formulation.7 The new formulation of SYSTANE® Complete with the nano-droplet technology resulted in increased moisture retention based on pre-clinical studies in comparison to SYSTANE® Balance lubricant eye drops.8,9

Aligns with the latest DEWS II Report, which recognizes not only aqueous-deficient and evaporative dry eye, but also mixed dry eye and recommends management focused on restoring tear film homeostasis.8

In my clinical practice it is rare to see a patient with purely aqueous-deficient dry eye. In fact, an overlap of both types of dry eye can be seen. A recent study looked at patients with dry eye and found that 30-70% of patients have at least one symptom of dry eye.10
PORT CHESTER, NY—Zyloware Eyewear releases new frames for its Randy Jackson and Leon Max lines for June 2018.

**Randy Jackson 1929** is a full-rim metal frame that comes in extended fit sizing. The frame comes in three colors—black, gunmetal, and black/gold and features zyl temples. RJ 1929 features spring hinges, snap-in nosepads, and the ability to accommodate progressive lenses.

**Randy Jackson Limited Edition X138** is a full-rim zyl frame with a straight top bar and rounded lenses. Available in two colors, matte black features matte black over brown horn, while navy fade has a navy to translucent blue front and navy blue temples. Both colors feature gunmetal rivets on the front. RJ X138 offers spring hinges and the ability to accommodate progressives.

**Leon Max 4059** is a full-rim zyl frame that has a sloping brow bar with geometric lens shape. The frame is available in three colors. Blush features a tan to mauve horn fade on the front with tan temples. Sage has a sage to tan horn fade front and sage temples. Slate has a dark to light blue gradient fade on the front and pearl blue temples. All three colors have the Leon Max globe logo on the temple. Leon Max 4059 has spring hinges for easy adjustments and the ability to accommodate progressives.

**Leon Max 4060** is a full-rim metal women’s frame. It features a designed top bar with open pattern on the front and is available in a modified oval shape. The frame is available in two color options, black and gold. Leon Max 4060 has spring hinges, snap-in nosepads, and can accommodate progressives.
Give your patients the lens with a smart combination of performance and value.
Marta C. Fabrykowski, OD, FAAO  Manhattan Eye, Ear, and Throat Hospital in New York City

Impact on health care, MBA at Yale, slow cooking

Why a hospital practice instead of private practice? The hospital where I work is nonprofit, so that is vital. I always wanted to make an impact on health care that enabled me to see patients in all walks of life, whether they’re on Medicaid and uninsured or an Upper East Sider with insurance. Practitioners are salaried in the hospital, so there’s less incentive for fee-for-service. If you are in a private practice, you take home what you bring in. Being in a hospital allows me to focus on patient care. I don’t need to think about billing, marketing, or my schedule. I’m able to see my patients and then go home; I work with other specialists: cornea, medical and surgical retina, neuro-ophthalmology, glaucoma. Being in a hospital allows me interaction with special branches.

What’s something your colleagues don’t know about you? How much I like to cook for a long time. Those recipes that say 6+ hours of preparation or 3+ hours of marinating plus 12 hours in a cooker. I’m efficient in the office, so it’s an opposite hobby that’s something low and slow.

Why an MBA from Yale? In order to functionally lead or make an impact in business, you have to understand business. You have to understand operations, funding, and the structure of companies. I don’t know that well enough to make use of that knowledge and to make decisions. I can identify trends, but how does that impact the business of health care and the business of insurance? So, to move forward with being able to make a larger impact, I need much greater understanding. Yale is close to New York City. Because it is an executive MBA, it allows me to stay at the hospital full time. It is important to me to be able to stay in my current job to innovate while here. Health care is a fluctuating behemoth that being at work while learning is integral.

What would you advise a young OD who wants to follow your path? My path is evolving. If their path is to work in a hospital and in ocular disease, I would say keep your interests in doing a residency. I became a Fellow of the American Academy of Optometry the year I finished residency, which was helpful for networking, so I recommend becoming a Fellow. If it’s business-oriented things or healthcare on the whole, an MBA and other graduate programs will get you in that arena.

What’s your guilty pleasure food? What I feel guilty about is that I don’t ever feel guilty about eating something. My mom taught us that whatever you feel like eating is probably what your body needs. I eat very healthy in moderation, most things. Maybe as I get older and my metabolism slows down, I’ll have a different view and start feeling more remorseful. [Laughs]

What would you advise a young OD who wants to follow your path? My path is evolving. If their path is to work in a hospital and in ocular disease, I would say keep your interests in doing a residency. I became a Fellow of the American Academy of Optometry the year I finished residency, which was helpful for networking, so I recommend becoming a Fellow. If it’s business-oriented things or healthcare on the whole, an MBA and other graduate programs will get you in that arena.

What’s the craziest thing you’ve ever done? Accepting this job. Near the end of my residency, I spoke with our glaucoma specialist about job interviews. He called to say, “I have a job for you I came to the hospital and the office was not built. I was given a hardhat, and they walked me through this area with only beams and plywood. I said yes without seeing a practice and with meeting a only few of the doctors. I’m a risk-adverse person, but it was the first time I took a leap of faith and it worked out. Still here, my first and only job! —Vernon Trollinger

To hear the full interview with Marta Fabrykowski: optometrytimes.com/MartaFabrykowski
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- Mixed Dry Eye

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