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The following summary was compiled at an international gathering of leading eye care professionals in November 2007 to discuss the state of presbyopia education and awareness among patients.

Presbyopia and Multifocal Contact Lens Awareness Among Patients

Presbyopia awareness has moved into the forefront of eye care practitioner thinking. With more patients requiring correction for presbyopia, including longtime contact lens wearers, and contact lens design and technology allowing for better vision and easier fits, communication about presbyopia and contact lenses is more important than ever.

Patient Education

The majority of presbyopes know that near vision diminishes in their 40s. However, few are aware of the term "presbyopia," and fewer than 20 percent say their eye care practitioner uses the term.[1] In fact, emmetropes, perhaps the most challenging presbyopic patients, are least likely to be aware of the term. Patients look to their eye care providers to keep them informed on their visual changes and what they can expect in the future.

Explaining presbyopia. All practitioners explain presbyopia differently. Some keep the explanation quite simple, such as a problem with focusing or entering a new "visual phase." Another common explanation is using an analogy to describe the physical changes in the eye. "We simply tell patients that the focusing mechanism inside the eye is not unlike ligaments and tendons elsewhere in the body," says Rochester, NY, OD Michael DePaolis, "and as we mature, much like these ligaments and tendons lose elasticity, so does the focusing mechanism. Therefore, we eventually start to have difficulty seeing up close."

Another explanation stresses the lack of flexibility and thickness of the lens. Says Tod McNab, OD, in Vancouver: "I discuss how these changes have been happening since the patient was born. This circumvents the 'Can I exercise my eyes?' argument because I emphasize that nothing is wrong with the ocular muscles, simply the lens is not as flexible as it used to be."

Regardless of which explanation a practitioner prefers, patients need to understand that their changing vision is normal and unfortunately won't improve. Most patients seem to understand that such changes are progressive and don't happen overnight. A model eye can help illustrate the explanation so patients can see exactly what the lens is and where it is located, as well as visually define presbyopia and other conditions discussed during the exam.

Practitioners differ on their use of clinical terms, such as "presbyopia," "myopia," and "hyperopia," in their discussions with patients. Some practitioners stick with layman's terms to avoid confusing patients and losing them during the conversation. Others give a clinical name to everything mentioned because many patients use search engines such as Google to look up information.

"The term 'presbyopia' in Chinese is very simple and much less biological," says Greg Wu, OD, in Hong Kong. "It means 'aging sight,' so patients understand the concept. Patients accept that they may not understand the biological process behind that loss in focusing power, so we use the model eye as well."

Many offices also provide pamphlets on presbyopia for patients to take home. This helps reinforce information discussed during the exam as well as provide a reminder for anything forgotten during the conversation.

Multifocal contact lenses. Awareness of multifocal contact lenses is low, even among current contact lens wearers — emmetropes have especially low awareness. However, once presbyopes become aware that multifocal contact lenses are available, they are very interested in learning more. What's more, one third of presbyopes claim they would likely switch to another practitioner if their current one does not mention multifocal contact lenses. "We should all practice by the mantra that a patient should never leave our practices and learn something elsewhere that he should have learned from us." says San Diego OD David Geffen.

Discuss before presbyopia hits. Most practitioners agree that educating patients about contact lens options for presbyopia should take place before the condition affects vision. In this way, patients know what to expect and recognize that their vision will change and what it means.

In fact, Dr. McNab uses dilation as a tool to demonstrate how the patient's vision will appear with presbyopia. "I mention that at some point in the future, their vision will look like that," he says. "About two years prior to the onset of presbyopia, I talk about how we will manage their vision changes."

Patients also tend to return to the practitioner who was proactive about discussing presbyopia and methods to manage their vision.

Explaining Multifocal Contact Lenses

The term "multifocal." Part of educating patients about vision correction options during presbyopia is explaining the term "multifocal." Although the term is very practitioner friendly, it may not be patient friendly – at least not without an explanation. With increased advertising from manufacturers, the term "multifocal" is becoming more familiar, but patients may still ask for bifocal contact lenses or lenses to help with reading or near vision. Once you explain how the lens works – that there are more than two zones of vision – the word "multifocal" seems more appropriate and actually highlights the benefit versus bifocal glasses.

Emmetropes and presbyopia. Patients are only somewhat aware of the specialized options for correcting their presbyopia with contact lenses, such as monovision and multifocals. Emmetropes have especially low awareness. In fact, eye care practitioners report they rarely recommend specialized lenses to non-contact lens wearers. They are enthusiastic about prescribing contact lenses to presbyopes…as long as those patients are already wearing lenses. However, this could be a missed opportunity.

You may think that presbyopic emmetropes can be challenging patients — they have no experience requiring vision correction and are faced with an array of choices which they know little about. Practitioners choose to address the condition with these patients in different ways.

Here are some successful approaches from your peers:

Dr. Mack spends more time with emmetropes explaining adaptation to contact lenses and comfort, fit and vision, especially the fact that vision may fluctuate in different light levels due to the pupil size changing. In addition, vision may be different in other settings, such as an in-office setting or a home or workplace setting.

"I use both a binocular and a modified monovision approach," says Milton Hom, Azusa, CA, OD. "We have had very good success presenting the options to our presbyopes who never thought of contact lenses. Most of the time they tell me, 'No one ever asked me.' They are willing to try and do well."

Some emmetropes entering presbyopia have questions about refractive surgery, thinking it can "cure" the condition. Says Dr. Geffen: "When we tell them that there is no variable focus surgery, we talk about options and suggest a contact lens trial. In doing these trials, I will put a multifocal lens on one eye, and the patient will say, 'I never knew that contact lenses could be so comfortable. I like the way I see, so why would I have surgery?' The patient transfers into wearing contact lenses at that point."

An emmetropic presbyope asking about surgery rather than asking about reading glasses as a treatment option presents a better opportunity for discussing multifocal contact lenses, Dr. McNab has found, because he has already expressed interest in a non-spectacle correction option. Upon learning that surgery is not an option, this patient is likely to be more willing to consider multifocal contact lenses — even though it may be a more complex and costly option than reading glasses.

Dr. DePaolis agrees. "Contact lenses make perfect sense for an emmetropic patient who wants to discuss LASIK," he says. "His presbyopia is clearly bothering him enough that he is willing to do something above and beyond just reading glasses."

Another point to consider is function and movement. Emmetropes have never worn glasses or experienced something on their face every moment of the day, with the exception of sunglasses. Adapting to frames and possible obstructed peripheral vision are challenges not encountered while wearing contact lenses, and should be pointed out to the patient.

Practitioners find that emerging presbyopes who don't currently wear contact lenses may be more adaptable to their changing vision by wearing multifocal contact lenses rather than multifocal spectacles. Patients reject multifocal spectacles greater than multifocal contact lenses due to the spectacle lens design adaptation needed.

Several visits for fitting. Most patients, even current contact lens wearers, aren't aware that fitting multifocal contact lenses can take a few visits to fine-tune the fit. Understanding that multiple visits are the norm is important for patients to realize. Also, explaining the goals of the fitting process helps set patient expectations, while assuring them they will receive the optimal fit to suit their visual needs. However, recent research revealed that patients are more than willing to come back three times for the optimal fit.

In order to set their mindset for multiple visits, one way to prepare them for multifocal fitting is to use precedence elsewhere. Many presbyopic patients may be taking medication for conditions such as high cholesterol or high blood pressure. Much like their physician adjusted doses of medication for their needs, eye care practitioners will adjust the fit or the prescription of multifocal contact lenses.

"We try to assure patients that fitting will take several visits," says Dr. Mack, "so they have the expectation that there will be several visits, and that we will work on this over time. I also assure them that their experience is normal because a patient who is not aware of the fitting process will think that he is not adapting to this as quickly as he should."

Multifocal contact lenses require a more specialized approach to fitting than standard single-vision lenses, so it stands to reason that multiple visits are becoming the standard procedure. Edinburgh OD Ian Cameron tells patients that the first lenses he orders are likely not the end result. "I say to them, 'These are your template lenses. Try them, see how they go and we will adjust them.' The idea of trial lenses or template lenses works quite well," he says.

Patients need to know that it is going to take more than one follow-up visit, on average, says Dr. Hom. Saying "about three visits on average" to the patient prompts him to think, "That is a number I can deal with, rather than 13 or so visits."

Manufacturer assistance. Contact lens manufacturers have made great strides over the past 10 years to improve multifocal contact lenses. From better design to better lens reproducibility, contact lens options have expanded to offer enhanced vision to presbyopes. Eye care practitioners already prefer multifocals over monovision, but continuously look for refinements in lenses or techniques.

The history of extended chair time, difficult fits and mediocre vision resulting from multifocal contact lenses remains in the memory of many eye care practitioners. "In the past, we were told about how great multifocal contact lenses were," says Dr. Hom, "then we were largely disappointed. There is always that specter behind us when we are thinking about using a new multifocal. At one point in time, the number manufacturers was reaching for was 50 percent. It was like flipping a coin. I am now a big believer in multifocals with today's technology. Success rates now are way past 50 percent."

"In the past, I was very hesitant to fit multifocal contact lenses," says Sydney OD Anthony Chapman-Davies, "but over the last 18 months, the technology has reached a point where this is my first option. I go to monovision now only if the multifocal doesn't work, and often I will use multifocal/monovision in one eye for existing wearers."

In addition to improved technology, practitioners are also looking for manufacturer guidance in other areas:

1. Achieving efficient outcomes, such as determining an optimal fit. For example, a patient returns for a follow-up visit. He is enthusiastic about comfort and his near vision; however, he would prefer his distance vision to be a little better. Practitioners would like to know the most expedient next step to solve the patient's complaint, instead of trying lens after lens and simply buying another two weeks.
2. Building awareness. In Hong Kong, there is little awareness of multifocal contact lenses, even among existing lens wearers. Dr. Wu would like to see more product-driven advertising and public awareness campaigns driven by manufacturers.
3. Sustaining the message. The challenge for the industry, says Dr. DePaolis, is a sustainable message. So much of presbyopic multifocal contact lens fitting is finding the right option at the right time. Practitioners may need to chat with patients about their three options: refractory surgery, contact lenses and eyeglasses, at every annual exam for 5 years in order to find that option at the right time.

Silicone hydrogel multifocals. With the launch of single-vision silicone hydrogel lenses, practitioners immediately clamored for multifocals. With the launch of Bausch & Lomb's PureVision® Multi-Focal, the long-awaited day has arrived.

"It is great to have the option of a silicone hydrogel multifocal," says Dr. Mack. "If I took a current single-vision silicone hydrogel lens wearer back to an older technology material, it almost seemed like a step back even though I was moving the patient into a multifocal lens. Sometimes you have to do some explaining if you earlier promoted the silicone hydrogel so much that the patient starts to question why you are not going into a silicone hydrogel."

Silicone hydrogel lenses may also help patients with dry eye. For presbyopes, especially women, dry eye is a common concern. Frequently patients refit into silicone hydrogel contact lenses experience fewer dry eye symptoms, and practitioners welcome this option for patients requiring multifocal lenses.

Says Dr. McNab: "I want all of my patients in silicone hydrogel lenses if possible for ocular health reasons. The dry eye issue is very real and can limit a large number of the presbyopic patient base from comfortable contact lens wear."

Fees for Presbyopic Contact Lens Correction

Once informed of the benefits of multifocals, presbyopic patients recognize their superior value and are willing to pay a premium price for the best vision possible. They understand the need for the additional fits necessary to achieve their visual needs and the fees associated with this process.

However, some eye care practitioners may assume that patients are unable and/or unwilling to pay these premiums and may not recommend multifocals as a result. Practitioners perceive higher cost as a barrier, when in reality it may not be. Limited or lack of communication about alternatives may contribute to the disconnect between what patients are willing to spend versus what the practitioner views as an acceptable cost to the patient.

Spectacles vs. contact lenses. Industry experts have questioned the difference between presenting higher-end contact lenses (such as multifocals) and higher-end spectacles (such as progressive addition lenses) to patients. Clearly patients are willing to spend money on higher-end spectacles, so why the breakdown with contact lenses?

In many cases, the person doing the "selling," so to speak, is different. Opticians and frame stylists usually work with patients in their frame and lens selection, and the final choice is often out of the eye care practitioner's hands—regardless of the doctor's recommendation.

"The high-end progressive lens market is completely different because it has a lot to do with fashion, style and designer names," says Dr. Hom. "I was at Nordstrom taking a look at their sunglasses. They have $200-$400 pairs of sunglasses which sell well because they are Fendi or other designers. In terms of multifocal contact lenses, I simply tell the patient, 'Let's try them on to see if you like them.' I like to get to the bottom line instead of spending

a lot of time explaining things. Put them on and you see whether you like them or not."

Professional and product fees. One approach that has proven successful in separating the practitioner and his recommendations from the topic of fitting fees & premium pricing is to have the staff conduct this conversation along with previously discussed options.

Dr. Geffen uses these words when he suggests multifocal contact lenses to a patient before deferring to a staff member to discuss fees and lens costs: "I have been fitting these new multifocal lens designs for a few years now. They have become much better than they were in the past. We have a very high success rate. Our patients are extremely happy with the vision. I would be happy to let you have a test drive and put a lens on right now and see if you like it. If you do, the fees for these lenses are a bit higher than regular lenses, but I am convinced that you will really like this, so let's give it a try. Let me have Carla come in and put a lens on you and see how it works."

Dr. DePaolis's office even schedules separate appointments for contact lens fitting and dilation, for example, to keep the lines clear between an exam covered by vision insurance and a contact lens fitting which requires an extra charge.

"Patients come in with an insurance card and pay their co-pay at the front desk," he says. "They think that entitles them to everything they are going to do with the doctor that day. We found that it was very difficult to differentiate between what the exam would cover and what ultimately would be the professional contact lens fitting. We try to push that discussion off simply so that the patient knows that is a separate event from the eye health evaluation, which has now transpired, and we find that the patients better understand the fees and better understand what is going on."

Some contact lens practitioners practice in an environment in which fees are never discussed by the doctor. Says Chicago-based OD Louise Sclafani: "I don't talk about contact lens fees with my patients in my setting. I assume that they are there because they want to be fit. However, I never fit a patient in contact lenses who doesn't have a pair of glasses to wear. Patients must show me the glasses, and they must get at least 20/25 or 20/30 vision in those glasses. This is important to me because patients without usable glasses perpetuate contact lens overwear and complications. I don't sell glasses in my setting, so I feel comfortable doing that."

In teaching environments, on the other hand, budding practitioners must learn how to handle fee conversations with patients. "We expect our interns to consult with their attending doctor to review fitting fees and lens costs before contact lenses are applied," says Dr. Mack. "Our staff is involved only in collecting the fees at the end of the visit. This allows our doctors in training to become comfortable with explaining fees and lens costs. They will admit that it is quite difficult at first, but most adapt well using the mindset that the patient has the right to decide if she feels what you are offering is worth the cost."

Monovision. Eye care practitioners believe multifocals provide superior clinical outcomes, profitability and professional satisfaction, while monovision performs best for fitting simplicity and patient economics. Most eye care practitioners charge a higher fee for multifocal fits than for monovision. But as was indicated before, presbyopic patients recognize the superior value of multifocals and are willing to pay a premium price for the best vision possible. As a practitioner, this means you'll also have happier patients and fewer dropouts in the long run.

Dr. McNab tells his contact lens-wearing presbyopic patients that they will obtain the best vision with single-vision contact lenses with reading glasses on top. He knows patients don't want that option, so his explanation prompts them to ask what other choices they have.

"When I am comparing monovision to multifocal vision," he says, "I talk about the fact that their eyes were designed to work together. Suddenly now, at age 45, we are going to ask their eyes not to. Why? It might work for a year or two, but eventually there will be a great enough difference between their eyes that they will not be happy. They will also have more trouble with intermediate distances while wearing monovision. That concept hits most patients right away because so many people work with computers in their daily lives."

Summary

Presbyopic patients are generally unaware and have minimal if any education pertaining to presbyopic contact lens options, especially multifocals. Once aware however, interest in multifocal contact lenses is very strong, particularly with existing contact lens users, but non-contact lens wearers also express interest — and practitioner recommendation can make a difference. Patients perceive strong value in the promise of multifocal contact lenses. They are willing to spend more — more than practitioners think — and go through a longer fitting process. Practitioners believe multifocal contact lenses are clinically superior to monovision, and while they were previously concerned about patient price acceptance, they are optimistic about research that shows that patients are willing to spend more for great vision. Overall, multifocal contact lenses represent a big practice growth opportunity, provided patients are well informed, educated and managed.

Reference:

[1]*Bausch & Lomb survey, July 2007. 538 consumers with presbyopia, aged 40-55 and 151 eye care practitioners.*

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