A SUPPLEMENT TO Contact Lens SPECTRUM® JULY 2012

# Multifocals: The New Standard of Care

*Part 2 of 2*

*A further review of highlights from a roundtable held during SECO 2012*

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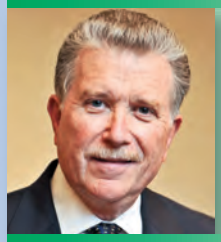
## MODERATOR



**John L. Schachet, OD,** is president and CEO of Eyecare Consultants Vision Source in Englewood, Colorado. He has received research grants and/or honoraria from Alcon and CooperVision.

## PANEL

**Dave Kading, OD,** is in practice in Seattle and is an adjunct faculty member at Pacific University. He has been a consultant/advisor to and has received research/education grants from Art Optical, Alcon, Contamac, Paragon, Valley Contax and Unilens.

**Steve Lowinger, OD,** has a private practice and retail practice in South Florida. He has received research funding from Vistakon and honoraria from Alcon.

**Jack Schaeffer, OD,** is the President and Chief Executive Officer of Schaeffer Eye Center, which has 15 locations in and near Birmingham, Alabama. He has been a consultant/advisor to and has received honoraria from Alcon, Allergan, AMO, Bausch + Lomb, Essilor, Hoya, Optovue, Vistakon and Zeiss.

**Christine Sindt, OD,** practices at the University of Iowa in Iowa City. She has been an advisor/consultant to Alcon and Vistakon.

*Support for this panel was provided by Alcon.*

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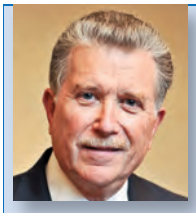
*Contact Lens Spectrum* is published by Springer VisionCare. 

# Winning Hearts and Minds

## *Multifocals are the contact lens standard of care for emerging presbyopes. Here's how to ensure a smooth transition.*

**Dr. Schachet:** The thinking around multifocal lenses has shifted somewhat, from something we recognize as a business opportunity to treat the growing demographic of presbyopic patients to a standard of care that we don't feel we can deny those patients. We have a duty to provide the best care, and multifocals give patients better vision than monovision, especially over time as presbyopia increases. We all need to get on board if we haven't already done so. The change will ultimately enhance our success and make patients happier, too. What do you tell your colleagues about multifocal lenses?

**Dr. Schaeffer:** I tell them you have to think of multifocal lenses as a new specialty, a new paradigm in your office. You're creating a compliant patient, which is what we're all trying to do, so think about this new paradigm in terms of how you take care of that patient. Look at how you handle them. How do patients explain their problem to you? How do you state your philosophy on making multifocals, not monovision, number one? How is your staff trained to help? How do you educate patients and follow up with them on the three visits they need?

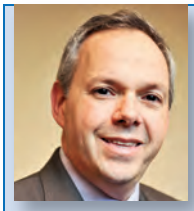


**We have a duty to provide the best care, and multifocals give patients better vision than monovision, especially over time as presbyopia increases.**

***— John L. Schachet, OD***

**Dr. Kading:** It's a specialty within our practice, but we don't have to be specialists to fit them. I think the way you get started, especially if you're a monovision fitter, is to use the fitting guidelines. Start fitting the easier patients — the emerging presbyopes. After 30 fits or fewer, you'll be very comfortable, and you'll be helping patients achieve the full range of vision.

**Dr. Sindt:** We all have to feel comfortable fitting this modality. Multifocal lenses are the standard of care, so we all have to get there.



**You can't discount a segment this large. You build a practice based on how well you take care of an entire family ... It means dealing with all of their medical and refractive issues — from sending them for cataract surgery to fitting them with a multifocal lens.**

***— Steve Lowinger, OD***

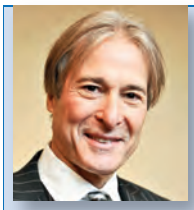
**Dr. Lowinger:** You can't discount a segment this large. You build a practice based on how well you take care of an entire family, and that means daughter and son, mom and dad, grandma and grandpa. It means dealing with all of their medical and refractive issues — from sending them for cataract surgery to fitting them with a multifocal lens. Saying "no" to fitting emerging presbyopes with multifocals is saying, "I don't want you as a patient."

You can't build your practice by excluding treatment options or the patients who need them. To me, that's a no-brainer.

### WHEN DO YOU START THE CONVERSATION?

**Dr. Schachet:** Do you wait until symptoms of presbyopia appear to discuss multifocal lenses with your contact lens wearers? Or do you start having that talk proactively as patients approach age 40?

**Dr. Sindt:** I think it's important to broach the subject before they have a problem. I tell them what they can expect in the future so they're aware that they need to bring those symptoms to my attention. I'm looking for clues such as decreased wear time — anything they can track on their own. If I have a patient who spends most



**I tell patients three simple things: 1) This is a new visual system for a new stage of your life. 2) You're going to go through an adaptation period. It could be a day; it could be a month. 3) Each time I see you, our goal is to develop natural, comfortable vision.**

***— Jack Schaeffer, OD***

of the day on the computer and perpetually checks his iPhone*, I have the discussion even earlier.

**Dr. Lowinger:** I call it looking in my crystal ball. When patients are 35 or 36, I say, "You'll notice these symptoms over the next few years. Don't worry. You don't have to stop wearing contact lenses and get bifocals with a line across them. We'll be moving you into cutting-edge technology contact lenses."

**Dr. Sindt:** That also ties patients to your practice. They'll be back when those symptoms start because they know you can help.

**Dr. Schachet:** Does anyone wait until symptoms appear?

**Dr. Kading:** I don't wait until 40 hits and presbyopia starts. My patients in their 30s are working on computers for 8 to 12 hours a day, and then they go home and read on their iPad* and iPhone*devices. They have so many issues related to eye strain and discomfort. They already need three pairs of glasses — computer, distance and sunglasses. When they start showing signs of presbyopia, why keep them in single-vision contact lenses? I explain that it's just like wearing the right sneakers for the right sport. These are the right contact lenses to reduce the amount of effort that their eyes have to put into using their computer. Patients get it. They don't think they're getting old; they understand that they're getting the right lenses for their daily activities.

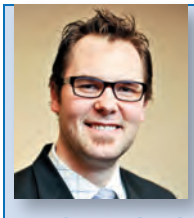
## SETTING EXPECTATIONS

**Dr. Schachet:** How do you set proper expectations for multifocal lenses?

**Dr. Lowinger:** We know what patients are going to encounter during the first week of multifocal lens wear, and we should prepare them. Honestly, I simplify things to the extreme. I say, "I want you to pay attention to three things this week: 1) How do you see far? 2) How are you reading? 3) Are you comfortable? If there are any issues with those three things, then we'll talk about it next week and make any adjustments." By limiting the conversation to the nuts and bolts, we get to what's important in a more efficient way.

**Dr. Schaeffer:** I tell patients three simple things: 1) This is a new visual system for a new stage of your life. 2) You're going to go through an adaptation period. It could be a day, it could be a month. 3) Each time I see you, our goal is to develop natural, comfortable vision. And those three things sort of set the stage.

**Dr. Sindt:** I agree with keeping it simple. Patients don't want lengthy conversations; they just their lenses to work. They're thinking, "You're the professional. Fix me, because I have another appointment in 30 minutes." I like to let them know that we're putting the near, intermediate and distance correction in front of their eyes at all times. Their eyes know how to see, but it takes a week or so to train or reset their brains.



**My patients in their 30s are working on computers for 8 to 12 hours a day, and then they go home and read on their iPad* and iPhone* devices. They have so many issues related to eye strain and discomfort. They already need three pairs of eyeglasses — computer, distance and sunglasses. When they start showing signs of presbyopia, why keep them in single-vision contact lenses?**

***— Dave Kading, OD***

It's also important to remember that expectations go both ways. I need to know what a patient expects. I think that's especially important now that we're seeing young multifocal patients who are reading mostly on phones and tablets. That use of their visual system influences how much of an add they're going to need and how early they're going to need it. As we discussed with the question of how early to introduce the lenses, communication gets patients what they need, when they need it, and it helps us create legacy patients — the kind that tell their friends what to expect and who can help fix it. ■

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# Multifocals in Practice

## *Practitioners with a success rate of 85% offer their pearls for getting started and getting the right fit.*

**Dr. Schachet:** We've established that multifocal contact lenses have replaced monovision as the standard of care. But how do you get started? And what outcomes can you expect?

### WHAT'S YOUR FITTING PROCESS?

**Dr. Schaeffer:** Once I recommend multifocals and explain what to expect, a technician comes in and explains the global fee, which covers the necessary visits. Next, the technician gets the lens that I chose and places it on the eye. After 5 minutes, the tech asks, "Are you seeing OK?" If the answer is "Yes," we wait for the 15-minute mark and perform an autorefraction and then refract over the lens — binocular and monocular — so we can fine-tune that day. About 15% say, "I just can't see," and I may try a different visual correction option. The other 85% will leave with lenses that get them close to 20/20 distance and 20/20 to 20/25 near.

If acuity isn't there, I'll switch to another lens and maybe perform topography to see why we're not getting the best result.

**Dr. Sindt:** This part of my practice relies heavily on my highly trained ancillary staff. My primary role is to ask questions, listen to the patient and choose a lens. I think patients really need to be heard, even if it's the eighteenth time that day that I've heard a similar presbyopia story. I know the patient is less likely to succeed if he doesn't think I've heard and understood his problem. My time is best spent having this conversation and fine-tuning the prescription. We dispense at the initial visit, and then I see the average patient back two more times.

**Dr. Lowinger:** It's a small group that won't succeed. At the first visit, when a good candidate has the lens in, we just ask, "How are you seeing?" We don't ask them to read a chart. We just want to hear, "Great." If the patient naturally feels like he's getting some decent vision, then we're on a path to success.

**Dr. Kading:** I'm not as tied up in the initial visit. We do an autorefraction over the lens, as well as topography. If the pupillary axis doesn't line up with the line of sight, and if a contact lens does not line up with the line of sight, then the patient's vision will be skewed. It's a simple check. If the lens is decentered, then the patient needs a different lens design or monovision. We check patients' binocular vision, rather than asking them how things look with one eye covered.

Aside from those tests, I have just a couple of requirements for my patients when they leave the first visit. First, they must be able to see to drive. If they can't see distance, they're going to come back and return the lenses. They also must be able to use their cell phones.

**Early presbyopes are easy breezy. You just put them in the lens, it fits and they see great at all distances. Discussions become a bit longer with more mature presbyopes.**

***— Christine Sindt, OD***

The most important visit to me is the second visit. They've already gone out and used the lenses in their everyday lives, so they have some feedback. And because the lenses have been on their eyes for several hours, I can fine-tune things.

### DO YOU USE THE FITTING GUIDELINES?

**Dr. Schachet:** Do you use the fitting guidelines for Air Optix Aqua Multifocal contact lenses? Do you recommend that other practitioners utilize the fitting guidelines when they begin fitting multifocals?

**Dr. Kading:** I was always the type of person to ignore the fitting guidelines because I knew how to do it better than the company's way. But over the years, particularly with Alcon, I've seen a change. They've enhanced the fitting guidelines in ways that really improve the way it works.

It has blown me away that the fitting guidelines recommend pushing plus at distance to improve near vision and avoid impairing distance. We always think to give more minus in that case. The baffling thing is that it works. And by following the fitting guidelines and using unified adds, I find that I'm more successful than I was without them.

**Dr. Lowinger:** With the fitting guidelines, there's no wrong answer. If you're not comfortable fitting these lenses yet, it's a great place to start. Or if your fitting set is collecting dust, the fitting guidelines are the only way you'll take that first step. You'll change things based on how your patients react.

The current fitting guidelines match what I'd already been doing with Air Optix Aqua Multifocal lenses, aside from the fact that I push the plus for my presbyopes in South Florida.

## WHAT ARE YOUR MULTIFOCAL LENS OPTIONS?

**Dr. Schachet:** We have several options for multifocals: Air Optix Aqua Multifocal contact lenses (Alcon), Biofinity and Proclear Multifocals (CooperVision), Acuvue Oasys for Presbyopia (Johnson & Johnson), and PureVision Multifocal (Bausch & Lomb). In your experience, do they differ in fitting, comfort or vision at distance, intermediate and near?

**Dr. Sindt:** Well, those are four very different materials, and each one performs differently on the eye in terms of comfort, deposition and longevity of lens wear. You have to know the differences and how they affect the patient you're putting them on.

**Dr. Kading:** Absolutely. The other component is that all of these lenses work better or worse for certain individuals at certain times, so it's wonderful that we have all of them in our toolbox.

**Dr. Schaeffer:** I probably could fit 70% of patients in any one of the four lenses, but I feel there's a slight advantage to the Air Optix Aqua Multifocal lenses. At Day 1, most patients leave with good distance and near, and the lotrafilcon material helps maintain moisture by minimizing the rate of lens dehydration. The end-of-day comfort is amazing — especially for patients who have had comfort issues in the past.

**Dr. Kading:** I agree. One other nice component that really stands apart with the Air Optix Aqua Multifocal lens is the asphericity of the design, which supports a full range of vision.

**Dr. Lowinger:** The thing I appreciate the most about the Air Optix Aqua Multifocal lens is the distance vision clarity on the initial fit. If you start blurring patients' distance vision, they dismiss multifocal lenses entirely, so these lenses make it much easier to get the patient to believe in this system.

**Dr. Sindt:** And the Air Optix Aqua Multifocal lens offers not just good distance vision, but also good near vision. Before I started using these lenses, I typically needed a high add for my patients, but I had to back off to medium with these lenses or they'd be too strong at near.

**Dr. Kading:** And patients are in the ballpark of where you want them to be within 20 minutes — not a day or two like some of the other lenses.

## WHAT'S YOUR SUCCESS RATE?

**Dr. Schachet:** You've all been consistently fitting presbyopes with multifocal contact lenses for years. What's your current success rate?

**Dr. Schaeffer:** In my practice, it's 85%.

**Dr. Kading:** I'm in that realm.

**Dr. Sindt:** That's about right.

**Dr. Schachet:** Are you equally successful in fitting emerging, mid-range and full presbyopes?

**Dr. Sindt:** Early presbyopes are easy breezy. You just put them in the lens, it fits and they see great at all distances. Discussions become a bit longer with more mature presbyopes.

**It has blown me away that the fitting guide recommends pushing plus at distance to improve near vision and avoid impairing distance. We always think to give more minus in that case. The baffling thing is that it works. And by following the fitting guidelines and using unified adds, I find that I'm more successful than I was without the guidelines.**

***— Dave Kading, OD***

**Dr. Schaeffer:** A pleasant and surprising change is that plano patients, who we couldn't help just 5 or 6 years ago, are now very easy to fit.

**Dr. Lowinger:** The other tough patients are high adds. They've had unsuccessful fits with other doctors

because they have a high reading demand, and they take the most time in my office. But challenging cases aside, the technological advances over the past 10 years have really helped us achieve new success through an industry-wide effort. We're all benefiting from these advances.

The Air Optix Aqua Multifocal lens is not hard to master after fitting five to 10 patients. The fitting guideline is the starting point in getting you comfortable with the lens and its design.

From there, you need to determine how your practice habits and patient responses on those first 10 or so patients "tweak" his initial lens decision.

In my case, I used the fitting guideline and realized that I was underpowering patients by about a quarter. I figured it was me not pushing plus enough or a vertex issue, but I added a quarter to my initial fits and that seemed to solve it. ■

# If your presbyopic patients aren't in AIR OPTIX® AQUA Multifocal contact lenses,

# they may *NOT* be seeing the full picture.

## Make a smooth transition with a great multifocal lens—AIR OPTIX® AQUA Multifocal contact lenses


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- Precision Profile™ Lens Design has a smooth transition from center near to intermediate and distance zones
- 96% of eye care practitioners agreed AIR OPTIX® AQUA Multifocal contact lenses are easy to fit[5]

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*AIR OPTIX® AQUA Multifocal (lotrafilcon B) contact lenses: Dk/t = 138 @ -3.00D. **Based on subjective ratings of intermediate and distance vision, and vision for daytime driving, night driving, and TV viewing. †In emerging presbyopes, among those with a preference. ††Among those with a preference. ^Trademarks are the property of their respective owners.

**Important information for AIR OPTIX® AQUA Multifocal (lotrafilcon B) contact lenses:** For daily wear or extended wear up to 6 nights for near/far-sightedness and/or presbyopia. Risk of serious eye problems (i.e. corneal ulcer) is greater for extended wear. In rare cases, loss of vision may result. Side effects like discomfort, mild burning or stinging may occur.

**References: 1.** Based on third-party industry report, Alcon data on file, Jan 2010-Sep 2011. **2.** Woods J, Woods C, Fonn D. Early symptomatic presbyopes—What correction modality works best? *Eye Contact Lens.* 2009;35(5):221-226. **3.** Rappon J. Center-near multifocal innovation: optical and material enhancements lead to more satisfied presbyopic patients. *Optom Vis Science.* 2009;86:E-abstract 095557. **4.** In a randomized, subject-masked clinical study at 20 sites with 252 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2009. **5.** Rappon J, Bergenske P. AIR OPTIX® AQUA Multifocal contact lenses in practice. *Contact Lens Spectrum.* 2010;25(3):S7-S9.

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