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# *Streamline* Your Soft Multifocal Fitting Process



Learn how these practitioners ensure satisfied patients, using proven multifocal technology and efficient fitting and management techniques.

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**David I. Geffen, OD, FAAO** is Director of Optometric and Refractive Services at the Gordon & Weiss Vision Institute in San Diego, Calif. Dr. Geffen has been an advisor to Alcon, AMO, Annidis, Bausch + Lomb, TearLab and V-Max Vision.



**J. Bradley Oatney, OD**, graduated from The Ohio State University College of Optometry in 1987 and practices primary eye care at Riverview Eye Associates in Columbus, Ohio. He is an optometric educator whose passion is speaking on effective patient communication and new eye care products. Dr. Oatney has recently started a free eye clinic in Columbus, Ohio. He is a consultant to the Center for Patient Insights, which is sponsored by Bausch+Lomb.



**Rhonda Robinson, OD, FAAO**, is in private group practice in Indianapolis, Indiana. She is a leader in the national optometric community and the founding president of Women of Vision, a mentoring organization for female optometrists. She is a frequent guest lecturer at the various schools of optometry in North America and continuing education programs for Doctors of Optometry. Dr. Robinson has been a consultant/advisor to Bausch + Lomb.

Mo Merchea, Director of Medical Affairs - North America at Bausch + Lomb, acted as moderator for this roundtable discussion.

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# Streamline Your Soft Multifocal Fitting Process

Learn how these practitioners ensure satisfied patients, using proven multifocal technology and efficient fitting and management techniques.

**Mo Merchea, OD, PhD, MBA:** The presbyopic population represents a tremendous growth opportunity in eyecare practices, as more than one-fourth of the U.S. population is between the ages of 40 and 59.<sup>1</sup> Our panelists have enjoyed long-term success prescribing multifocal contact lenses, a relatively untapped market, and today they share how they engage current and prospective contact lens wearers in the discussion of presbyopia. They also discuss how they manage patients' expectations and changing visual demands, which are often driven by their use of computers and personal electronic devices, and panelists offer time-saving fitting and patient management tips. Let's begin with that all-important first conversation about presbyopia.

## STARTING THE PRESBYOPIA DISCUSSION

**Dr. Merchea:** When and how do you begin discussing presbyopia with your patients?

**J. Bradley Oatney, OD:** I used to wait until patients were in their early 40s before talking about or addressing presbyopia, but I've realized it's beneficial to start the conversation when they're in their mid- to late 30s. Preparing the patient makes the transition easier.

**Ami Abel Epstein, OD, FAAO:** I start the conversation when patients are in their mid-30s. I explain that they're approaching a time when their eyes will get tired of focusing and need some help, and that's normal for everyone.

**Rhonda Robinson, OD, FAAO:** My philosophy is to introduce multifocal contact lenses sooner rather than later, so I start talking about presbyopia and multifocals long before patients have symptoms.

**Dr. Merchea:** What are the typical complaints from patients who are just starting to experience symptoms of presbyopia?

**Dr. Robinson:** Generally, patients first notice a change in their near vision, but as Dr. Epstein mentioned, a less obvious symptom is eye fatigue. Interestingly, people in their early years of presbyopia who work on computers all day may be able to maintain focus for work, but they notice problems with their distance vision when they drive home at the end of the day.

**David I. Geffen, OD, FAAO:** I have noticed increased complaints of dry eyes among some of my patients in their late 30s. I used to think we had a real dry eye problem, but upon further investigation, I found many of these patients were staring at a computer screen all day straining to see clearly and not blinking properly. I've fitted patients like these with multifocal contact lenses and, suddenly, the dryness symptoms resolved because the patient was able to see clearly.

**Dr. Oatney:** A common complaint from patients just starting to experience the effects of presbyopia is that they're having problems reading text messages and other information on their cell phones. I understand their frustration because so many details of our lives — appointments, e-mails, contacts, to-do lists — are stored in our phones.

## EXPLAINING THE OPTIONS

**Dr. Merchea:** How do you present the vision-correction options available for presbyopia?

**Dr. Geffen:** Basically, I tell patients they have three options, and I explain why I strongly recommend multifocal contact lenses. Then I encourage them to take the lenses for a "test drive" for a week or two.

**Dr. Oatney:** I briefly describe monovision, but quickly move on to my preferred option, multifocal contact lenses.

I tell patients that with multifocals, they can typically see well at most distances most of the time.

**Dr. Robinson:** When I start hearing complaints of tired eyes from contact lens wearers who are in their late 30s, I know it's time for a demonstration. While the patient is wearing his lenses, I have him view a near-point card or his mobile phone through +0.75D handheld trial lenses. Patients may not see a difference right away, but when I remove the trial lens, they can usually feel their eyes refocus. Then I say, "Imagine your eyes doing that hour after hour all day. That's why your eyes are tired. I can put this power that I'm holding in my hand into your contact lenses. You will be able to see distance and close, and sustain your focus for longer periods without being so tired. Do you want to give them a try?" You'll notice that I don't use the word multifocal until they have tried them and love them.

## MONOVISION VS. MULTIFOCAL: NO CONTEST

**Dr. Merchea:** Many practitioners use monovision correction for early presbyopia and then try to introduce multifocals as presbyopia advances and the limitations of monovision become readily apparent. Why did you shift from fitting monovision to fitting multifocal contact lenses as your primary management technique?

**Dr. Oatney:** What helped me make the transition was hearing so many former monovision patients say how much they preferred their vision with the multifocals when I refit them. Having patients coming back excited about wearing multifocal contact lenses has really influenced my fitting habits over the years. My experience has been that multifocals outperform monovision. The majority of my patients choose multifocals over monovision.

**Dr. Epstein:** I always start with the multifocal option. For me, it's a philosophical choice. If all of my time as an eye-care professional is spent trying to give patients binocular vision from childhood to presbyopia, why would I give them monocular vision with monovision?

I explain that multifocal contact lenses will help their eyes work together synergistically to see at all distances, and that's why I prefer them.

**Dr. Robinson:** I think patients intuitively understand why it makes sense to use both eyes together. To try to explain monovision takes more time. It's complicated, and patients really don't understand it. I don't believe monovision is easier to fit. In fact, I think multifocal contact lenses are easier to fit and easier to explain to patients.

**Dr. Geffen:** I never start with monovision. I assume my patients want the best vision possible at every distance. I

*Having patients coming back excited about wearing multifocal contact lenses has really influenced my fitting habits over the years. My experience has been that multifocals outperform monovision.*

*— J. Bradley Oatney, OD*

agree that it takes more time to explain monovision — that we're doing something to dissociate the two eyes and that this may produce some blur — than to explain how multifocal contact lenses work. I'm amazed at how many patients are blown away when I tell them about multifocal contact lenses because they've never heard of them. They become my best referral sources.

**Dr. Merchea:** What are your thoughts on modified monovision?

**Dr. Epstein:** When a person has astigmatism to the degree that I cannot fit him in a multifocal, I'll choose a toric lens for distance for the dominant eye and use a multifocal for the other eye, which provides some binocular overlap in vision from near to distance. That approach — what I call blended vision — has worked nicely in my practice.

Another example of blended vision is when I use a low add for one eye and a high add for the other eye. I usually do this for a patient who needs two high adds, but whose distance vision isn't where it needs to be, even with additional minus power.

**Dr. Robinson:** That's exactly how I use modified monovision. I will try just about anything to help a patient. My first choice, of course, is full binocularity, but I may use a different brand or two different brands or a toric on one eye and a multifocal on the other. There's something for everyone. It's just a matter of figuring that out and giving the patient time to adapt.

## REALISTIC EXPECTATIONS

**Dr. Merchea:** What do you say to patients to help them understand what to expect from multifocal contact lenses compared to a spectacle correction?

**Dr. Epstein:** I let patients know that no one correction, whether with eyeglasses or contact lenses, will give them perfect vision everywhere. There is always some compromise, but I believe multifocal contact lenses will meet most of their visual needs.

**Dr. Robinson:** One reason I like to start patients in multifocals early is because setting expectations involves a shorter conversation. If you're starting a multifocal with a 55-year-old, you must explain how the lenses work, talk about lighting and so on. I also mention that progressive spectacle lenses have a "sweet spot," a small area with correction for intermediate distances, and I explain that if they spend a lot of time at a computer or do a lot of detail work, keeping their eyes steady in a particular spot in the spectacle lens can be tiring. One of the true advantages of multifocal contact lenses is that you can see at all distances, in all directions of gaze, with great peripheral vision. When you think about a compromise of vision, in my opinion, the bigger compromise is with spectacles.

**Dr. Merchea:** Do you discuss how correcting for intermediate or near vision can affect distance vision with a multifocal contact lens?

the lenses for a minimum of 2 weeks but no longer than 3 weeks, so they can adapt to the design. When they return, they say they don't notice a difference.

**Dr. Robinson:** The earlier you introduce a multifocal design, the easier it is for patients to adapt to it because there's less distance compromise initially in a low add. If you can get patients into multifocal contact lenses early, when it's easier to adapt to the aspheric design, then it's easier to adjust the power as they age, and it's not as big an adjustment for them as you introduce a change in add power.

## FUNCTIONAL VISION VS. THE SNELLEN CHART

**Dr. Merchea:** There's an art to balancing distance, intermediate, and near vision for presbyopic patients. What are your thoughts about our professional desire to drive patients toward a 20/20 line as opposed to providing the best functional vision?

**Dr. Geffen:** Acuity measurements are not always as relevant to what a patient needs functionally from their vision. If they can't see their phones, for example, it doesn't matter what they see on a distance eye chart in my exam lane. We need to be aware of our patients' real life needs. Acuity measurements don't necessarily reflect success, and too often we hear recommendations about fitting multifocal lenses based on distance acuity measures when patients are coming to us specifically for improved near vision.

**Dr. Epstein:** What we measure in the office isn't what patients live with every day, which is why I want my patients to go out into the world with their multifocal lenses for 2 to 3 weeks and then come back to see me.

**Dr. Robinson:** I tell patients, "In here, you're looking at black letters on a white background in perfect lighting. I want to know what your vision is like in your world."

**Dr. Merchea:** How do you demonstrate functional distance, intermediate and near vision in your office?

**Dr. Epstein:** After we apply the lenses, I send patients to the waiting room and suggest they check their e-mail, send a text message and do whatever they normally do on their phones. That's real life. When they return to the examination room, I ask if they were able to see well to use their phones.

**Dr. Oatney:** I have patients walk down the hall and look at one of our computers. They appreciate being able to look

*“My philosophy is to introduce multifocal contact lenses sooner rather than later, so I start talking about presbyopia and multifocals long before patients have symptoms.”*  
— Rhonda Robinson, OD, FAO

**Dr. Geffen:** When I fit patients with a multifocal for the first time, I explain that, initially, they may notice their distance vision in my exam chair isn't quite as crisp as it is with their single-vision lenses, but I emphasize that I expect they'll be much happier with their vision with the multifocals because they won't have the eye strain they've been experiencing. Within a week or two of trying multifocal contact lenses, most patients have adapted and tell me their vision at all distances is good.

**Dr. Epstein:** I explain that the lens has more than one power and is designed to focus for distance and near at the same time, so it takes some getting used to. I have patients try

up, down and to the side and then view the computer screen without needing to point their nose and adjust their chin, as they would with progressive spectacle lenses. Then I ask them to look at their phones. When they can see well at all distances, by simply changing their gaze slightly, it brings a smile to their faces, and I know the conversation is over.

**Dr. Geffen:** We have to gear our correction for what's important to the patient. It's all about the chief complaint. Too often, we get caught up in tests and we lose sight of why the patient came in.

Typically, it's about improving their vision, and that's what we have to focus on.

**Dr. Merchea:** Dr. Robinson, can you assess functional distance vision in your office?

**Dr. Robinson:** The layout of my office is ideal for checking functional distance vision. Outside my examination rooms, there's a hallway with a window. The bank across the street has a sign that is perfect to use as my eye chart. My patient and I step into the hallway — I have my +0.25D and -0.25D flippers in my hand — and I ask him to look at the bank sign. If he's not satisfied with his distance vision, I'll add +0.25D or -0.25D as needed right there in the hallway, while he's looking at the bank sign across the street, as opposed to looking at an eye chart while sitting in the chair with the lights turned down and counting letters.

## EASY-TO-FIT MULTIFOCALS = LESS CHAIR TIME

**Dr. Merchea:** What is your experience fitting the PureVision Multi-Focal and the SofLens Multi-Focal contact lenses? How many follow-up visits do you typically need for the average patient?

**Dr. Oatney:** Both lenses are easy to fit. If you set expectations up front and choose the best lens based on your examination, typically it takes two to three visits.

**Dr. Robinson:** I agree. On average, I need only two or three visits. Fitting these lenses is very straightforward. Again, keeping patients' expectations — and your own — realistic is important. For example, a patient may say she can see well for driving, working on her computer and using her phone, but her near vision could be a little better for crocheting. At that point, you have a win. You may need to remind the patient that she may need to use reading glasses for specific tasks, but for 90% of what she does, these lenses work well. I think sometimes practitioners get caught up in trying

for perfection when they don't hit 20/20+ at distance. Their chair time increases, and soon they decide multifocal contact lenses are perceived as difficult to fit, when they actually had a good fit to begin with.

**Dr. Merchea:** All of you have experience fitting numerous multifocal designs. What features are indicative of an easy-to-fit multifocal?

**Dr. Epstein:** In my opinion, we really only need a distinct low add and a high add design. I can't remember a time

***“ In my opinion, we really only need a distinct low add and a high add design. I can't remember a time when a low or high add didn't meet my patients' needs. — Ami Abel Epstein, OD, FAO ”***

when a low or high add didn't meet my patients' needs. The more adds you have, the more confusing it can be for the practitioner, particularly when the actual add power in the lens isn't significantly different between the adds.

**Dr. Oatney:** I agree. Personally, I couldn't detect a difference between the range of presbyopic patients that I could fit with a three-add product and a two-add product. I've stayed with the PureVision Multi-Focal, because it's simple to fit and I know I can count on a high add with enough add power.

**Dr. Robinson:** With the PureVision Multi-Focal and the SofLens Multi-Focal, the low add is a slam-dunk every time for emerging and early presbyopes. There's very little if any distance compromise, so it's really easy to fit. As patients age and need more add, I simply switch them to the high add. If it's a little too much, I add some minus to the distance prescription. As they age, I gradually decrease the minus until they're into the full add. It's a simple, straightforward fit.

**Dr. Merchea:** Alexis Vogt, PhD, and colleagues used wavefront-sensing Hartmann-Shack-based technology to study the power profiles of multifocal lenses.<sup>2</sup> By mapping the power across the radius of the lens much more accurately than a lensometer would allow, they demonstrated how the add power is generated and the distinctions between add powers, depending on the design. Is it important to you to have multifocal designs with optically distinct labeled add powers?

**Dr. Robinson:** Absolutely.

**Dr. Epstein:** Yes. For example, one multifocal lens has

three adds, but the medium add and the high add appear to have the same profile. The low add, in fact, is no different than the distance-only aspheric lens in the same material. When add powers are essentially the same, how are we to know which one to choose?

**Dr. Geffen:** It gets confusing from the practitioner's point of view when you put on a  $-3.00D$  with a medium add and it doesn't work well and you go to the high add and that doesn't work well either because the power profile is the same as the medium add. This lack of power distinction between lenses is what can increase chair time. The optics of multifocal lenses are critical, and manufacturers provide wavefront power profiles of lenses with multiple add powers so we can see the differences. In these cases, using a lensometer to measure the power in the contact lenses is just ineffective.

**Dr. Oatney:** I believe having two add powers and knowing how to add and subtract minus from the distance prescription is more effective and much more efficient for fitting multifocal contact lenses.

**Dr. Geffen:** I enjoy the availability of the high add to serve the needs of my advanced presbyopes. We especially

high add OU for binocularity and then add plus to the non-dominant eye as needed. Also,  $+0.50$  added to the non-dominant eye works very well and certainly better than monovision or modified monovision.

**Dr. Epstein:** The high adds in the Bausch + Lomb multifocals allow me to fit advanced presbyopes because they actually give a notable increase in the near vision. There are times that the high add can cause a mild blur at distance, but that usually goes away after an adaptation period of about 2 to 3 weeks. If it doesn't, I consider reducing the distance plus (or increasing the minus) by about  $0.25$  to  $0.50$  over the dominant eye.

## FULFILLING ASPECT OF PRACTICE

**Dr. Merchea:** We've learned today the top priorities for success with multifocal contact lenses: starting the presbyopia discussion before symptoms emerge, fitting patients in multifocal contact lenses early, setting realistic expectations for functional vision and testing functional vision, and using an easy-to-fit, well-designed aspheric-design lens. Your closing thoughts?

**Dr. Geffen:** Many practitioners still seem to have the

idea that multifocals are difficult to fit. I hope our discussion has changed that perception.

**Dr. Epstein:**

Transitioning patients from the PureVision2 single vision lens into the PureVision Multi-Focal design is seamless in our practice.

**Dr. Oatney:** It's a very fulfilling part of the practice

when I can give an emerging presbyope what he's looking for or a mature presbyope something he didn't know was possible. It makes for an enjoyable day.

**Dr. Robinson:** The payoff for fitting multifocal contact lenses is that we can make people happy with these lenses.

*“ Acuity measurements are not always as relevant to what a patient needs functionally from their vision. If they can't see their phones, for example, it doesn't matter what they see on a distance eye chart in my exam lane.*

*— David I. Geffen, OD, FAO* ”

find the patients who have been wearing a multifocal design can easily adapt to the high add. I'm often surprised at the quality of the distance vision in many of my patients using the high add design.

**Dr. Oatney:** I've had the most success fitting advanced/mature presbyopes in the PureVision high add multifocals. Many of these patients said their doctor had never discussed contact lenses as an option and they assumed they weren't able to wear contact lenses. I have enjoyed helping many retired patients have success using the high add lenses. These patients have referred many of their curious friends to see if they are candidates for contact lens wear!

**Dr. Robinson:** For advanced presbyopes, I utilize the

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