Listen, look and learn

Could a toric soft lens that truly met the needs of astigmats be a game changer in contact lens practice? **Alison Ewbank** joined a roundtable meeting of experienced practitioners to hear their views

Consider this question: when correcting vision, do we often focus on the correction or fitting we are trying to achieve as a practitioner rather than what the patient actually wants and needs?

Addressing unmet needs was the key issue for a panel of contact lens practitioners convened by Bausch + Lomb for a roundtable meeting in Berkshire. The meeting brought together practitioners from The Netherlands, Belgium and the UK to discuss B + L's new toric soft lens, PureVision2 HD for Astigmatism.

Optometrist **Imran Khan**, until recently based in Holland, set the scene. Clinical success with toric soft lenses might be regarded as reading 6/6 on the Snellen chart and no lens rotation at the slit lamp. Functional success, on the other hand, required a patient-centred approach, more concerned with quality of life and satisfaction with vision correction, and in everyday situations rather than in the consulting room.

Khan drew a parallel with low vision rehabilitation, where although the functional goal differed from patient to patient, the fundamental aim was to meet the patient's needs.

Less than satisfied

Among contact lens-wearing astigmats, there was evidence that satisfaction and vision could be improved. The NSIGHT (Needs, Symptoms, Incidence, Global Eye Health Trends) Study, commissioned by Bausch + Lomb in 2009, found that more than one in three (38 per cent) of those who reported astigmatism and wore contact lenses were less than satisfied with their lenses.

Nearly half of all astigmats (47 per cent) experienced blurry vision and almost nine in 10 (88 per cent) of those reporting blurry vision were bothered by it. A similar proportion of contact lens wearing astigmats (86 per cent) said they would be bothered by losing access to their contact lenses, suggesting a strong desire to continue with lens wear.

A survey of 201 toric soft contact lens wearers (Consumer Toric Needs Study, Millward Brown, 2010) found that the most frequent as well as the most troublesome issues were blurry or hazy vision, followed by distorted or fluctuating vision, and glare or halos in low-light conditions.

When asked how important various product attributes were when deciding which brand of torics to choose, the top five attributes cited all related to vision and the top three related to vision 'all day', 'throughout the day' and 'at all times'.

Communication was key for the UK panel members

Khan said there were many potential causes of blurred or hazy vision in contact lens-wearing astigmats. The practitioner might leave astigmatism uncorrected and fit a spherical lens, and the patient could be unaware of toric lenses as an option. Poor stability and excess rotation with soft torics might be responsible, or physiological factors such as dry eye and eye rubbing.

For Khan, the key clinical test for a patient-centred approach was the history and symptoms. 'We have an opportunity to improve both the vision and the personal satisfaction of our patients. It is getting easier to meet their needs but we still have to listen to them,' he said.

The reluctant practitioner

Chairman **Dr Christine Purslow** had a simple question for the UK panel: why are practitioners still reluctant to fit soft torics?

Time constraints and lack of experience were the first to spring to mind, so some might take the easy option of fitting spheres. 'There's a large proportion of practitioners who are afraid to fit torics because they're supposedly difficult to fit,' observed **Dr Sandip Doshi**

'Perhaps they tried fitting torics more than 10 years ago when lenses were very thick and then encountered problems,' said **Susan Bowers**, adding that the need to order lenses in and re-book the patient for trial might also be a deterrent.

Annette Latham-Jackson was among those who argued that getting patients to come back to the practice for trial fitting made them feel they were getting better customer service or, as Doshi put it, 'a special lens made for them'.

So what advice did the panel have for practitioners who were reluctant to embark on toric fitting? One recommendation was always to trial a lens that was close to the patient's correct prescription. **Peter Ivins**' advice was to carry out an accurate, up to date spectacle refraction since correcting the full cyl was crucial with any soft toric. Others suggested avoiding problem patients when starting out and building confidence with relatively straightforward fits.

'Don't be afraid to experiment,' said Latham-Jackson. 'The first lens

UK PANEL MEMBERS

- Chair: **Dr Christine Purslow**, Cardiff University
- **David Bennett**, Brooks and Wardman Optometrists, Nottingham
- **Susan Bowers**, Susan R Bowers Optometrists, Coventry
- **Dr Sandip Doshi**, The Eyecare Centre, Hove
- **Peter Ivins**, Peter Ivins Eye Care, Glasgow
- **Annette Latham-Jackson**, Jackson and Gill Opticians, Hay-On-Wye
- **Vinod Mistry**, Camden Contact Lens Centre, north London
- **Brian Tompkins**, TK&S Optometrists, Northampton

you try in somebody's eye won't necessarily work. If you're a newly qualified practitioner you might be slightly concerned about that. With experience, we all know that it may be the fifth lens you try that's the Eureka lens. Build a rapport with the patient and explain that to them.'

Probing more deeply

Was a different vocabulary needed for discussing vision with astigmats and eliciting visual problems? And should practitioners be asking specifically about halos and glare? Latham-Jackson often questioned patients about vision in low-light conditions and headlights when driving at night, while Ivins introduced questions about halos and glare during the slit-lamp examination.

More probing was required with toric lenses to elicit dynamic aspects of vision and problems with stability. 'But is there a natural reluctance to say "Is it going badly?" because then we'd have to fix it?' asked Purslow.

There were various different approaches. Bowers used the question: 'When you blink does your vision stay stable or does it change?' **Vinod Mistry** asked patients what symptoms or problems they had with their lenses in different situations. **Brian Tompkins** simply favoured, 'Are there any problems we can help you with?' while Ivins asked, 'Are there times when your contact lenses let you down?'

Latham-Jackson's approach was to ask patients about their visual experiences during the day – at the computer, at work, outside. I wouldn't say specifically "are your lenses stabilising" because they wouldn't necessarily know.' Doshi tended to be more specific and ask whether vision was 'consistent throughout the day'.

Ivins made the point that, once wearing contact lenses, motivation to continue wearing them was very strong. With toric lenses, there was a belief that wearers accepted their vision fluctuated but would not offer that information for fear of having their lenses taken away from them, unless specifically asked.

For the practitioner, reluctance to probe too deeply was a question of 'have I got the time and have I got the solution', he said.

Starting out

For **David Bennett**, it was important to determine patients' motivation from the outset. 'Ask them the first time you fit the lens: why have you come to see me, why do you want contact lenses, and what do you want to do with them?' Mistry encouraged new wearers to jot down any issues and come back in a week if they had a problem or three weeks if all went well.

There were various ways to describe the choice of lens, such as avoiding saying, 'This is the best lens for you' and opting instead for, 'There's a range of lenses available that are suitable for you'. Some practitioners also had to overcome their own reluctance to suggest a more expensive product even when it was a better solution for the patient.

Design attributes

Purslow opened the discussion of lens design by asking the panel how much thought they put into choosing a soft toric based on the stabilisation method that the lens used: 'Is it in the decision-making process?'

Most had a first-choice lens regardless of stabilisation method but used a range of lenses to achieve an optimum result for the individual patient. 'You need to have several different designs to make sure you have a stable fit on everyone because not every eye is the same,' argued Bowers. Ivins agreed: 'The reality is you can't fit everyone with one design at this point in time. You need two or three designs.'

Many factors determined Mistry's lens choice. Availability of prescription parameters, lens shape, fitting characteristics, stiffness of materials and lens thickness were all involved.

Was a trial and error approach adequate since manufacturers were investing millions of dollars and years of research in new lens designs? 'If you said here's a lens that works and stabilises every time on every patient – if you could predict stabilisation – then we'd buy that but the reality is you don't know that. It's predictability that's been the issue,' said Ivins.

Susan Bowers: challenging patients

'You don't know until they actually go and wear the lens. Lenses can behave one way in the consulting room and in real life very differently,' added Bowers. The consensus was that there was no substitution for putting lenses on eyes and for building up experience with new designs as they emerged.

The science of stabilisation

Opinions varied as to whether prism ballasting or dynamic stabilisation achieved better results. 'Sometimes with oblique cyls, my feeling is that dynamic stabilisation isn't so good,' said Latham-Jackson, whereas Bennett said multi-zone designs using the melon-seed principle 'felt about right'. Mistry favoured B + L designs, adding: 'I think they've had more stable lenses than other manufacturers in the past.'

Ivins made the point that if a prism-ballasted lens did not work, another lens of the same design might not work either. Perhaps practitioners needed to appreciate the science behind these designs to know what to do when a first-choice lens did not stabilise, said Purslow.

One fitting attribute, speed of orientation, was less of an issue with the latest designs, as Ivins explained: 'If it's moving around a lot after a couple of minutes I'll try another design right away. We've moved away from "let's put this in, wait an hour and come back". They all settle.'

There was general agreement that vision and comfort were related. 'If the vision's spot on, they get more comfort but if the vision's terrible they complain about poor comfort,' said Bowers.

The new design

PureVision2 HD for Astigmatism introduces two new design attributes aimed at improving vision and satisfaction for patients. The lens incorporates aspheric optics first used in the PureVision2 HD lens to reduce halos and glare in low light conditions. Spherical aberration is reduced in both the spherical and cylindrical meridians and, as with the spherical lens, aberration control is optimised across the power range.

The other new feature is a hybrid ballasting technique, termed Auto-Align Design, which B + L says uses the best aspects of prism and peri ballasting to orientate and stabilise

the lens and achieve consistent fitting across all powers. The lens also has a 14.5mm diameter – larger than the original PureVision Toric but with a similar sagittal depth – to improve centration and acuity, and a large optic zone to reduce glare in low-light conditions. Another new feature is a letter-based Lens Power Identifier for powers, axis and orientation.

PureVision2 HD for Astigmatism also incorporates B + L's ComfortMoist Technology: a thin lens design with the same rounded edge profile as the spherical version, and poloxamine in the packaging solution for comfort on insertion.

The UK panel members had been asked to fit 10 patients with the lens and discuss their experiences. Presenting his results, Ivins concluded the lens delivered exceptional vision, fitted well and was easy to fit. It was very stable, orientated quickly and initial comfort was very good.

Fit and vision

Doshi had fitted new wearers and refits, all but one of whom was successful. 'I was pretty impressed. When I asked about their quality and consistency of vision, I had unsolicited reports of night vision being particularly good. Refitted patients said the lens was on a par or better than previous lenses. In terms of fitting and vision it was definitely a success,' he said.

Latham-Jackson's eight patients were aged 18-63 years and all were successfully fitted. 'The fitting is very easy and consistent. 'The vision was very successful and good. Patients were pleased with the vision and had comments like "vision doesn't change – it's the same most of the day', "my initial feeling is that the lenses are really clear" and "vision is excellent and I loved that".'

Annette Latham-Jackson: don't be afraid to experiment

David Bennett: determine motivation

Summing up the lens, Latham-Jackson said it was 'brilliant from a fitting point of view and brilliant from a vision point of view', with just one or two comfort issues mainly with her older, female patients. 'PureVision2 HD for Astigmatism is an excellent lens for neophytes who need torics and haven't worn lenses before,' she added.

For Bennett, the lens had 'probably one of the best stabilisations' he had come across. 'It's very, very simple. It comes to vertical within seconds. Once you've got the vision corrected, it's great – no problems with stability, centres nicely and the markings are brilliant. On the lens design front, Bausch + Lomb have nailed it. The design is absolutely superb.'

Among other panellists, Tompkins particularly liked the easily visible markings. Bowers had tried the lens on existing toric wearers with challenging visual needs, some of whom said they preferred the lens for night driving. The toric users Mistry had refitted reported that vision was sharper than with their previous lenses.

Avoiding dropout

The discussion then turned to a problem that practitioners like to think affects only their competitors: contact lens dropout. The dropout rate is known to be higher for astigmats and, in the past, they have been less successful than non-astigmats when they try lenses again. Despite the advent of comfort enhanced lenses, astigmats continue to drop out which suggests that poor vision may be a factor.

The answer was not simply to encourage more practitioners to fit more torics but to meet patient needs. Mistry said some practitioners did not have the motivation to try and upgrade patients to new lenses that might help them continue lens wear. 'I normally spend time, especially with those who've dropped out of lens wear before, explaining that whatever happens you've got to come back and tell me if it's not working. I may say "I want you to wear lenses – it's good for my business".'

For Ivins, retention was all about customer service and the experience they were given. Statistics from outside optics showed that when customers were not loyal to a particular retailer, in 70 per cent of cases it was because of the company's indifferent attitude to them as a person.

The game changer

Much of the day's discussion had focused on overcoming practitioner reluctance to fit torics and to probe too deeply their patients' needs. Finally, Purslow posed the deal-breaker question: given a lens design that could be easily and successfully fitted to almost all astigmats and keep them in contact lenses, would the barriers to toric lens fitting be overcome?

For the practitioner, there were many 'reasons to try harder', she argued. It might be money, business, patient loyalty, skills or job satisfaction that pressed people's buttons and motivated them to try harder. But one of the reasons could be that products had got better. On the evidence of this particular panel of experienced practitioners, they just had.

TIPS FOR OVERCOMING BARRIERS TO TORIC LENS FITTING

- Keep abreast of new products and the latest developments in toric designs
- Gain hands-on experience with the latest lenses
- Build confidence with straightforward toric fits rather than problem patients
- Use a variety of lens designs to achieve an optimal fit for each patient
- Fit empirically from an accurate refraction or use a toric lens calculator
- Select a trial lens as close as possible to the patient's correct prescription
- Use open questions to elicit visual symptoms at aftercare
- Probe more deeply by asking about visually challenging situations
- Record the proportion of all soft lens fits in your practice that are torics
- Benchmark your prescribing rate against annual prescribing trends for the UK
- Update your skills with regular contact lens CET