

Surgical solutions for keratoconus and designing a practice logo are two topics not often seen together on a conference programme and are at opposite ends of the spectrum of what practitioners might need to know. Both found space on the agenda for this year's BCLA Pioneers Conference.

More than 250 BCLA members gathered at the Royal Society of Medicine in London to hear lectures on two themes – Focus on Keratoconus and Practice Matters – followed by the annual BCLA Pioneers Lecture.

Put together by Pioneers organiser Nigel Burnett Hodd, the half-day programme also included a tribute to 50 years of soft contact lenses, invented by Professor Otto Wichterle at Christmas 1951.

Specialist subjects

Three refractive surgeons opened the clinical session, each presenting new approaches to managing keratoconus. According to consultant ophthalmologist **Dr Bruce Allan** (Moorfields Eye Hospital), the incidence of keratoconus was about one in 2,000 rising to one in 500 in people of South Asian descent. One in five keratoconics would go on to have a corneal transplant over five years.

Corneal collagen cross-linking (CXL) to arrest cone progression worked best in young patients, early cases and corneal thicknesses >350 microns. Since early diagnosis was key, Allan recommended referring suspected keratoconics sooner rather than later so that treatment could be initiated.

David O'Brart (Guy's and St Thomas', London) said that CXL was a natural ageing process in the normal

Beyond the borders

This year's BCLA Pioneers Conference offered professionals the chance to hear the latest on keratoconus management and a session on how to communicate with patients more effectively



The three surgeons: Sheraz Daya, David O'Brart and Bruce Allan

eye. The mechanism for CXL in keratoconics was not fully understood but clinical evidence, including prospective randomised trials, had shown that the treatment worked.

For O'Brart, those with early to moderate keratoconus and who were well motivated and well informed were the best candidates for CXL. Contact lenses should be left off for 3-4 weeks before treatment and patients warned they would experience pain for the first few days after surgery. Stromal haze occurred in all patients and reported complications included keratitis.

Transepithelial CXL involved fine incisions rather than complete epithelial removal and was less painful. Future developments might include non-incisional techniques, accelerated treatment with topical application of drops and no UVA, and even cross linking children's scleras to control myopic progression.

Dr Sheraz Daya (Queen Victoria Hospital, East Grinstead) said that advances in refractive surgery had brought about a change in the management of keratoconus. Newer modalities included intracorneal inserts (Intacs and Ferrara rings), phakic IOLs (Visian Toric, Artisan, Artiflex) and deep anterior lamellar keratoplasty (DALK).

In many cases grafts could now be delayed or avoided. Practitioners had an important role to play in the early

diagnosis of keratoconus and corneal topography should be mapped for all astigmatic patients.

Co-host of the Pioneers Conference **Dr Eef van der Worp** (Washington DC and Amsterdam) reviewed the contact lens options for the irregular cornea. Although 10-20 per cent of keratoconus patients would eventually have surgery, contact lenses were often still required postoperatively. They could also postpone surgical intervention and decrease the risk of corneal scarring.

Soft lenses for keratoconus needed to be much thicker than normal, eg 0.38mm. Other options included piggyback (RGP over soft), 'pillow pet' (RGP inserted into anterior surface of soft lens), reverse piggyback (soft over RGP) and soft/RGP hybrid designs.

RGPs were the healthiest option if fitted well, ideally in alignment, and could correct 90 per cent of corneal irregularities. Highly aspheric and quadrant-specific lenses were among the latest designs available, but for van der Worp, scleral lenses that provided true corneal clearance were the future for correcting keratoconus.

His presentation set the scene for the evening BCLA Pioneers Lecture which revealed new findings on scleral shape 'beyond the corneal borders'. The shape of the limbus and anterior sclera was often tangential rather than curved. Many eyes were non-rotationally symmetrical beyond



Dr Eef van der Worp and BCLA president Shelly Bansal



the corneal border and might require toric or quadrant-specific lenses.

Practice matters

'How to talk so your patients will listen and listen so they will talk,' was the title for the opening lecture in the practice management session from Craig Wilcox. Patients only remembered 10 per cent of what you said and the first 10 words were the most important, he said.

Ten rules for effective communication included advice to 'turn on the emotional air-conditioning', use the patient's 'personal ringtone' (his or her name) and employ 'word magic', such as 'wake and see lenses' rather than 'orthoK'. The four words every patient used were 'What does that mean?' And Wilcox's advice? Tell them before they ask!

Dr Katharine Evans (Cardiff University) looked at ways of predicting successful contact lens wearers. Signs such as lid wiper epitheliopathy and lid-parallel conjunctival folds were useful predictors of contact lens-induced dry eye.

Strategies for improving wearer comfort included changing daily disposable lens wearers to comfort-enhanced lenses, changing the care solution to one that enhanced lens surface wettability, improving compliance and remembering the importance of a healthy tear film lipid layer.

For Edinburgh optometrist **Ian Cameron**, the opportunity to gain the patient's trust made contact lens practice fulfilling as well as rewarding. His guide to greater satisfaction in working life was to identify the target patient profile and tailor the practice offer accordingly, from the practice logo to consulting room design. 'Everything about your practice tells your patients about you,' he said.

His advice was to think about the words you would like to be associated with your brand, such as 'passionate', 'trusted', 'individual' and 'expert', and reflect this in all aspects of your practice.

Keith Cavaye used his experience as a General Optical Council member to highlight legal and fitness to practise issues in contact lens practice. He warned that patients must have an in-date, written, signed spectacle prescription no more than two years old in order to be fitted.

Handling instruction must be supervised, with a registered practitioner on the premises, and a contact lens specification given on completion of the fitting. Good practice was that it is in the best interests of the patient to be seen at least every year, said Cavaye.

Patient communication specialist **Sarah Morgan** looked at ways of empowering staff to promote contact lenses, using tools such as the EASE approach, applying lenses as an aid to spectacle dispensing. To allay patient fears, use the analogy 'Like a raindrop on the eye' and let them touch the lenses before trying them. 'Rest', 'place' or even 'float' the lens on the eye, rather than 'insert' it, she advised.

Be prepared for the question 'How much are your contact lenses?' and be aware that patients asking it are not necessarily price-sensitive. The message was that well trained frontline staff are as key to successful contact lens practice as even the most highly skilled practitioner. ●

Acuity testing in your pocket

Bill Harvey tries out the latest electronic acuity system

I have been using electronic acuity displays for more than a decade now and they have many advantages over the older backlit charts. Charts can be immediately changed, from, for example, a standard Snellen display to an ETDRS or logMAR set up.

Randomisation allows patients to be constantly challenged without the introduction of error through memory. Contrast may be adjusted to assess visual performance under a variety of external conditions. Patient cooperation is enhanced by the use of sequential targets of interest, particularly useful with children. On the occasions I undertake domiciliary visits, the use of electronic displays on my laptop has made 'in home' assessment much more accurate.

Flexible friend

Medmont has recently introduced an electronic acuity testing system – the AT20P. A development of the existing ATP20R, the system has greater flexibility and can be operated on any existing Windows operating system using a handheld smartphone via a wi-fi signal. This makes it a very flexible system and should be easy to incorporate into any practice or domiciliary setting.

Along with the usual acuity charts (Figure 1) and targets for cross cylinder and balancing, there is an array of fixation targets including an animated target to help keep the attention of the most distracted child patient (Figure 2). There are also binocular tests and a selection of gratings. The standard letter charts may also be displayed in lower contrast. Acuity and contrast ability can be assessed by a 'staircase' method whereby a simple scroll on the hand set allows the target to decrease in size or contrast until no longer seen. The system also includes a comprehensive library of good resolution clinical images to help educate the patient (Figure 3).



The test is available as a free sample download (be warned, it does have 'sample' written all over it) via the website www.medmont.com.au/products/at20p-acuity-tester.aspx. ●

● For further information on the AT20P contact BIB on 01438 740823 (www.bibonline.co.uk).