GP Lenses without tears
Q&A responses by
Scott Brown and Pauline Bradford, Scotlens

1 How do GP lenses compare to hybrid or scleral lenses for patients with corneal irregularities?
Corneal GP correct irregularities as well as hybrids or sclerals. Hybrids or sclerals may be better for very decentred cones/pellucid. Sclerals better for post-graft.

2 Are there any tips or tricks to help patients to adapt to GP lenses?
Using anaesthetic at A&R helps so that they aren't distracted by the lens sensation and first impressions are positive. Think about the language you use and the power of suggestion too. I've seen students say 'Now this is going to be really uncomfortable' before they put the lens on so guess what - it is!

I find saying something like 'You will be most aware of the lens for the first 30 seconds so keep your nose up and look at your knees to start with (minimises lid interaction with lens edge), count to 30 (gives them something else to focus on) then gradually bring your gaze up. They are usually quite happy within a minute with this approach, and it gives them a coping strategy to use at home too. It is best to use the instruction before you put the lens on as they don't listen afterwards.

3 Are there any common challenges that patients experience when trying GP lenses and how can it be addressed/improved?
Initial comfort but demonstrating the benefits such as the improvement in VA can help to keep them motivated.

4 In our practice our two older Optoms don't mind seeing GP patients, but our younger one seems to stay clear of them. Is this in your experience fairly common and how do we encourage younger OOs to fit GPs?
It will be lack of experience and confidence as Optom students have very little exposure to GP's, some literally only fit 1 or 2 before they qualify. Educate them on the reasons why this is a useful skill and maybe get them to shadow the older optoms and learn from them or show them how to take pictures with a smart phone and access lab support, so they know they aren't alone with it.

5 Do you like using an OCT for the assessment of scleral lens fit?
Yes, it easy, quick and accurate for vault. It removes the need to put fluorescein into the lens so less messy and you have images from the OCT to send to your lab.

6 When measuring the fluid layer behind a scleral lens do you just look at the central cornea, or should you look at the peripheral fluid thickness as well? This question relates to mini sclerals.
You need to look across the whole cornea. The lens design will have a recommended minimal clearance which can be assessed centrally on a regular cornea but on an irregular one, the cone can be low and the clearance then insufficient even if it was ok centrally. You need to check that the lens fully clears the limbus too, although clearance here will be less than centrally. With our lens we recommend minimum centrally of 300 microns and around 100 at the limbus as an example.

7 With the minimal clearance for a scleral: is it only centrally or for the whole cornea?
Generally central but can vary based on design so check the fitting guide for the lens you are using.

8 Can corneoscleral lenses be fitted with only a keratometer, without a topographer or diagnostic set?
Yes, empirically from K readings works well with regular corneas. A fitting set is an option for regular corneas and essential for irregular ones but no topographer needed.

GP Lenses without tears
Q&A responses by
Scott Brown and Pauline Bradford, Scotlens

9 Are corneoscleral lenses the same as minisclerals?
No a scleral bears entirely on the sclera and vaults over the cornea and limbus regardless of it's diameter. A corneoscleral bears partly on the cornea and partly the sclera and vaults over the limbus.

10 How do Keralenses react on dry eyes, and how can we improve wearability?
Discussed in webinar

11 Which trial lens are you using for this keratoconus fitting?
Corneal Scotlens KC2, EasyScleral

12 Would you advise keratoconic patients not to rub their eyes? I believe CXL won't halt progression but hopefully help to slow it down.
Always advise no rubbing, CXL is pretty successful at halting in majority of cases.

13 Can you fit keratoconus px without a topographer?
Yes.

14 How often do ortho-k lenses need to be replaced?
Annually

15 I have a 10yo child who has stopped myopia control soft daily CL as one eye "turns in". Corrected VAs are 6/5 OU. Would you expect the eye to do this with Ortho-K?
Yes probably.

16 What is the maximum rx for Ortho K?
Generally, -5.00 for it giving quality VA with no residual Rx. But patients can tolerate residual Rx and still be 20/Happy. I generally won't attempt >-6.00 as too much chair time can be lost.

17 Can you explain how blood/what pushes forward to reduce /prevent axial length in myopia management?
The choroidal blood flow reacts to the aberrations created with myopia control optics.

18 How would you suggest we grow the myopia management business by double in a short amount of time, given the high prices of myopia management at present?
We need to ensure we deliver the correct messaging to patients regarding myopia and myopia control. Not all will be able to afford the current prices. As a business we can only supply what we can afford to do. With pressure and demand from patients (encourage patients to write to MPS, College/ABDO to campaign to NHS increased funding will become possible.

19 What are your thoughts on wearing myopia control soft lenses and myopia control glasses for the same patient?
No evidence to suggest at the same time is more beneficial.
Discussed in webinar

20 Regarding Myopia Management and Ortho-K, how can you measure axial length change with standard topography?
No. Axial length needs measure with biometry. See MYOPIA WEBINAR for some axial length information.

GP Lenses without tears
Q&A responses by
Scott Brown and Pauline Bradford, Scotlens

21 Is it beneficial to use topographer to map cornea with young patients to screen for Kerataconus routinely?
Yes. Every young person with a Rx change should be screened in case it is keratoconus.
See this short article HERE

22 Can you recommend a good online site (or other) to learn how to use a topographer well?
All the topography principles are the same. But each manufacturer should be able to provide training on the use.
https://scotlens.com/wp-content/uploads/2024/04/Scotlens-custom-fit-contact-lenses-Topography-General-Topographer-Guide.pdf
or
https://vimeo.com/showcase/9600272

23 What daily disposable type, material and power would you use as a piggyback lens?
Discussed in webinar. Any low modulus daily disposable.

24 What type of lenses that were discussed in this session are the fastest growing type that is fitted?
Orthokeratology night lenses

25 Can wearing night lenses impact long term eye health?
No. Lots of evidence around this. MK infection rate is the same a daily disposable at 5 infections per 10,000 years of wear. No long-term theoretical concerns or proven concerns regarding the epithelial changes. Epithelial changes occur with all contact lens modes.

26 Why does anaesthetic at first wear increase success rate if the second wear is without anaesthetic?
First impression last! See this SHORT ARTICLE

27 Do you find that some lens materials are more beneficial for a particular age group of patients?
No, I generally always fit a high Dk material like Boston XO. This is good for all applications. Lower Dk benefits like being harder wearing are not clinically significant.

28 What would be your first choice for keratoconics - mini scleral or corneal keratoconinc eg Rose"K GP lens?
Small corneal lens is always 1st choice for patient wearing longevity.

29 What advice would you give to a newly qualified CLO who wants to do specialist fitting and get into hospital work?
Work in a clinic, either private or NHS. Volunteer if needed, you won't need long to get confident.

30 Will I need to be a Scotlens customer to use the website training opportunities?
No. Free via website for all!