Myopia management 2026; What works, what doesn't and what we still don't know
Q&A responses by Byki Huntjens

1. At what age can a child start ortho-k and atropine?
   Ortho-k: usually considered from about 6 years onward, if the child and family can manage lens wear safely.
   Low-dose atropine: licensed in the UK from age 3 to 14 years for eligible children, although most published evidence is in school-aged children.

2. Does an optometrist need IP qualification to use atropine?
   Correct. In the UK, Ryjunea® (low-dose atropine 0.1 mg/ml, licensed by Santen) is a prescription-only medicine. It may be prescribed by independent prescribers (IP) with relevant scope of practice, including IP optometrists and ophthalmologists with appropriate competence in paediatric myopia management.

3. Do you think that in time the use of atropine drops will be as popular an option along with spectacle lens and soft lenses within high street opticians
   I think atropine could likely become a mainstream option, but alongside (not instead of) optical treatments, particularly in combination strategies.

4. How do you see the future use of combined therapies in the UK now that the MHRA have approved the use of atropine for myopia control?
   See above (3). In combination with spectacle or contact lens options, under co-management with IP practitioners.

5. Would you feel there is a place for using atropine as a monotherapy
   There is for some patients. But its strength is most likely through combination therapy so the dose can be reduced and cause less side effects

6. If practitioners are going to use combination therapies, should they do so if they do not have access to AL measuring and can only measure SER change?
   You can start and manage myopia control using SER only, but AL gives you a clearer and earlier sign whether treatment is working, especially with combination therapy.

7. Is it true that atropine is now licensed to be used in the UK? What does it actually do?
   Correct. More information can be found here: https://www.college-optometrists.org/news/2025/november/mhra-licensed-low-dose-atropine-myopia?

8. Are there side effects if using atropine?
   Absolutely. Common side effects are 1) light sensitivity (photophobia) due to pupil dilation; 2) blurred near vision from reduced accommodation; and 3) glare, especially outdoors. Side effects increase with concentration, but Low-dose atropine (0.01–0.05%) is generally well tolerated

9. Would atropine therapy be more successful than contact lenses alone?
   This depends on the type of contact lenses, and also on the patient (compliance)

10. How do we use red light therapy?
    Currently the manufacturers recommend 2x per day for 3 minutes, 5-7 days per week, using a dedicated device emitting low-intensity red light

11. Could red light be available in practice - if we were trained?
    Yes. But this is currently not standard of care due to concerns about potential retinal effects and long-term safety

12. Is the red-light therapy available in the UK or just in China?

Myopia management 2026; What works, what doesn't and what we still don't know
Q&A responses by Byki Huntjens

It is available in the UK in a limited way: currently used mainly in research or specialist settings, not routine practice. Most evidence comes from Chinese populations where myopia management is much more common

13. Is the red-light therapy the same as the photobiomodulation machines that are available? My chiropractor uses this as a treatment for muscle repair and when talking to him his mother-in-law has noticed her AMD stabilising since using it regularly.
No. They are related, but not the same in purpose, protocol, or evidence.

14. Where can we find more on red-light therapy?
*I would recommend to start with the latest **International Myopia Institute** IMI paper: https://iovs.arvojournals.org/article.aspx?articleid=2810837*

15. In your experience does Ortho K have better results in Myopia Management than the new generation soft Contact lenses?
In my opinion, yes but only if the child is compliant. But it highly depends on commitment and parent support! But also be aware that there are no robust head-to-head randomised control trials (yet) showing one is consistently better.

16. Is there a study that compares the effectiveness between MiSight and spectacle lenses that reduce the progression of myopia?
There is currently no high-quality head-to-head randomised trial directly comparing MiSight with modern myopia control spectacle lenses. So, although both MiSight and myopia control spectacle lenses are effective, with broadly similar effect sizes, we cannot definitively say one is superior.

17. Is there any update on whether myopia management will become available on the NHS?
Not currently, but with licensed atropine and NICE appraisal underway, there is a realistic pathway for future NHS involvement.

18. Do you prefer spectacles or contact lenses for managing myopia ?
There is no single preferred option. It depends on the child and family. The best option is the one where the child will actually wear it consistently and correctly. Think about motivation, engagement, ability (to handle), lifestyle, and compliance.

19. What is the latest opinion of dual wear myopia management i.e. wearing m/m spectacles most of the time and m/m contact lenses for sports/social, also vice versa? Will it affect the effectiveness of one method by using another method also?
We don't know yet for sure, but initial (non-RCT) reports show very promising results related to compliance and effectiveness. Also see above (18)

20. What is the optimum age for beginning myopia management and how long should a patient expect to continue it? And at what age on average would you typically think myopia control spectacle lenses stop being effective
Start as early as possible once myopia is confirmed and progressing (typically 6-12 y/o), usually until mid-teens (15-18 y/o). On average, I would recommend start early, continue through the growth years, and expect treatment effect to taper as natural progression slows in the late teens.

21. When you say help the future generations do you mean that we can stop the myopia sooner or somehow help them genetically?

Myopia management 2026; What works, what doesn't and what we still don't know
Q&A responses by Byki Huntjens

No, I meant reducing risk and severity across the population. We are not changing genetics. Although myopia is partly genetic, it is strongly influences by environment and behaviour. So, education about time outdoor, less near work, and potential management options is the best we can offer.

22. Why do the public know about myopia management instead of presbyopia?
Good question. Possibly because myopia is talked about because we can prevent harm; presbyopia is accepted because we can only manage it.

23. With the results we have discussed this evening which option of myopia control would you recommend as first choice for your patient?
Unfortunately, this is impossible to answer, because it highly depends on the child and their parents (see 18)

24. A common question I get is if the child wants to carry on the myopia management into their teens does it still help? is there any research into this?
Yes, The IMI paper (Onset and Progression of Myopia in Young Adults 2023) mentions that myopia management can still be worth continuing in the teens, particularly if the prescription or axial length is still changing. Once progression has genuinely stabilised, there is less benefit in continuing.

25. My worry when dispensing myopia control spectacles to children is after they leave the store, the measurements and fittings are not stable when they come months later, how much does this affect the outcome for the child.
Regular review appointments are essential to confirm that myopia-management spectacles remain well-fitted, correctly aligned, and comfortable. Children and parents should also be advised to return immediately if the spectacles become misaligned or require adjustment, as this may impact both comfort and treatment effectiveness.

26. Can you offer any advice for explaining myopia control in "layman's terms" i.e. to a patient in a way they will understand and not overwhelm?
Maybe something like this: 'Your child's eyes are growing a bit too long, which is why their prescription is getting stronger. These treatments don't cure myopia, but they can slow down how quickly it gets worse, to protect eye health later'.
I would try to avoid percentages ('60% reduction'), technical terms (axial length, defocus), and listing too many options at once (group instead)

27. Did any of the studies look at how much of a factor genetics is in the prevalence or development of myopia?
Yes. Genetics plays a significant role (around 5-35% of variation), but myopia is now understood as a combination of genetic risk and environmental exposure. Genetics determines the susceptibility and potential severity, while environment determines whether is develops and how fast it progresses.

28. Do we think that there will be any financial support in the future for the cost of myopia lenses
I'm not sure

29. Were there any practitioners on any of the studies who used just one myopia control lens when the other eye has such a low amount of myopia that it means there isn't an available myopia control lens?

Myopia management 2026; What works, what doesn't and what we still don't know
Q&A responses by Byki Huntjens

I have had a few children who fall into this category & haven't been able to give them myopia control lenses. Would you advise using just one myopia control lens at all for the more myopic eye?
Myopia management spectacle lenses are now available from +0.50 D, such as those manufactured by Caledonian Optical, which may be clinically beneficial in selected cases.

30. Do you know of any plan to increase NHS voucher values to help with the cost of Myopia control spectacles? Prescribed multifocals have a higher value than single vision, for example, so why not myopia control?
I'm not sure. Also see above (17)

31. Are there any methods of MM we can recommend to anyone between the age of 20 to 30?
If eye growth is not stable, you could recommend the same management options as you would in children. However, there are no robust RCTs currently available to show its effectiveness. Also see the IMI paper (Onset and Progression of Myopia in Young Adults 2023)

32. If you have a young px that is Plano with some cyl correction - would you recommend myopia control asap or wait until sph is myopic pwr?
If the spherical equivalent is plano I would not start myopia control. Instead, I would increase time outdoors and manage near work habits. If the spherical equivalent is myopic, I would discuss options with parents.

33. I'm a newly qualified DO from Northern Ireland, and am finding it tricky to get people onboard with myopia-controlled lenses, especially as the NHS voucher cannot be used for it and the area, I work in is quite deprived, what are the best methods or talking points to use?
All you can do is provide clear, honest information, which it sounds like you are already doing. Ultimately, the decision sits with the parents and child. Focus on: why it matters long-term (eye health, not just prescription), and what the options are (including doing nothing!). To build understanding I would review every 6–12 months, and show prescription change over time, plus ideally growth charts. (axial length if available)

34. How much can we trust the manufacturers claims in regard to how effective their products are?
You can generally trust that the claims are based on real data, but it's important to look closely at how the results are presented. (absolute versus relative change)

35. It says outdoor time barely slows the progression of those who are already myopic, so is it still worth discussing? It is difficult for children to spend time away from screens as most education requires it.
It's true that reducing screen time completely is unrealistic, especially with school demands. But encouraging breaks from near work and time outdoors after school and weekend is still worth discussing. Outdoor time has a stronger effect on preventing myopia onset, but it still plays a supportive role once a child is already myopic.

36. Why is sufficient daylight important?
Increased light exposure stimulates retinal dopamine release and helps inhibit axial elongation.

37. Does the success of the therapy depend on the lifestyle of the child?
Correct! This may include sports, screen use, routine, etc. Also see above (18)

38. Can we use these references to direct parents when they ask for resources and research?
No I would recommend to use a website that is written for parents, not for ECPs. For example, I refer parents often to My Kids Vision: https://portal.myopiaprofile.com/clinicalresources/category/mp-resources/Details/my-kids-vision-qr-codes

Myopia management 2026; What works, what doesn't and what we still don't know
Q&A responses by Byki Huntjens

39. How do you best describe the benefits versus cost to a parent who is on a tight budget?
See above (33)

40. Is the increase genetic or environmental? How would a study establish this?
See above (27)

41. Does any, one treatment show the best or worst rebound after drop off?
We currently see the greatest rebound after stopping high dose atropine, less so after stopping lower doses. That's why you must taper gradually. The other options show some evidence of rebound (ortho-k) but data is limited and variable. Or minimal rebound (with soft CLs and spectacle lenses).

42. How do you explain to parents when they ask why their child's prescription is changing and increasing although they are wearing MiSight as recommended?
The eyes will still grow, so we still expect some change over time. So, I would say something like 'Your child's eyes are still growing, which is normal at this age. The lenses are helping to slow that growth, but they don't stop it entirely'.

43. Please would you elaborate a little more re "Side Effects" from the Conclusion slide.
No serious adverse events were reported in any of the included studies. But the duration of follow-up in the studies may have been insufficient to capture long-term or rare adverse events.

44. Do other papers use forest plots?
Yes, forest plots are used in systematic reviews and meta-analyses, but not individual clinical trials.

45. Where can you find the Cochrane review article?
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD014758.pub3/full
There is also a plain language summary available in many languages, which is helpful (third point in contents list on right hand side.

46. Any new developments in the pipeline
Yes. The field is evolving rapidly, with advances in pharmacology, optics, and combination therapies. Ongoing work in atropine includes optimal concentration, when to start and stop, and tapering strategies. So more about how we can use this best. More work on combination therapies, which will support the patient's lifestyle and enhances compliance and effectiveness. Some new customised spectacle and contact lens designs which take age and risk profile into account. Light-based therapies needs more evidence and research on safe usage. And novel drugs focussing on scleral biomechanics to directly influence eye growth.