

## Practice Development Series

### Specialty Lens Fitting: Patient Testimonial and Practitioner Pearls

Q&A with Katie Brown, OD, MBA  
An interview with Craig W. Norman, FCLSA



#### **Craig Norman**

Dr. Brown, can you talk us through what the fitting process is for a patient you are refitting from corneal lenses into scleral lenses, like the patient you discussed during tonight's webinar.

#### **Dr. Brown**

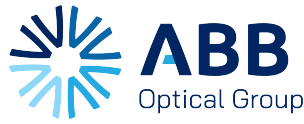
I think one of the biggest factors is taking a look at those corneal lenses on-eye to see how poorly they may be fit. So in this patient's case, he had a lot of apical bearing. We know that's going to affect his corneal topography, and we know that he's going to have to have a time period where his cornea will need to stabilize.

All of this comes into play when I begin the fitting. Step 1 is looking at what the patient comes in wearing. Step two is communicating with the patient. People are a little apprehensive of scleral lenses in general, because they are so much bigger than what they're used to. So usually, I just reassure them. I say these are going to be bigger. We have to put them on, in a different way and you have to take them out in a different way than you're used to.

I reassure them that the benefits that they are going to receive from these lenses will far exceed the insertion and removal learning process. The rest of the exam is just a normal scleral lens fitting. You just go through the fitting steps and know that you will have some fluctuation in vision and refraction on follow-ups. Just have a plan to re-assess those lenses and over-refraction. Maybe go back to the diagnostic lenses, especially if you're getting some funky over-refraction or cross-cylinder. Try to make it as simple as you can. At the follow-ups, sometimes you may put the trial kit lenses back on the patient's eyes and just start over if you need to. The goal is to check to see if the patient's corneas and over-refraction are stable.

#### **Craig Norman**

The patient you shared with us this evening was from around three and a half hours away from where you're located. You're relatively in the center part of the state? Is it common thing for you to see people from that far away?



## Practice Development Series

### Dr. Brown

Oh, absolutely. It's very common. Most people travel at least a couple hours. He was an extreme case since he lives on the border of Missouri and Arkansas, but no doubt patients come from the four corners of the state. There are times where I wish I could see them back in a week or two for follow-up, and they can't come. This means that I adjust what I would normally do and what would be the best for the patient. I absolutely must take into consideration that travel time. They're not getting ideal care because of that travel distance, but at least they're getting scleral lens care, and most of the time, the fitting is far superior to the lenses they had been wearing previously.

### Craig Norman

Have you toyed with the idea of using telemedicine at all in these cases?

### Dr. Brown

I really have. Right now, at the university at the Jones Eye Institute, we're doing tele-retina. Retinal photos are being sent from some of rural areas clinics, and our retina specialists give their opinions on retinal cases. So, it's definitely crossed my mind to be able to use other OD's and eye care providers around the state to say look at this patient in a week and send me some photos of the fitting. It's been a little harder with COVID, as we just haven't seen each other face to face to build this type of network.

### Craig Norman

Yeah. It's hard to build that network just online alone. You mentioned a couple of the things that our guest patient went through. Can you describe something that is very common, and you addressed it this evening - that is midday

fogging? What are your steps are for managing that?

### Dr. Brown

I'm lucky in that most of the midday fogging issues that my patients experience are usually from the outer surface fogging. So, first you have to figure out the sources. Is it the outer surface, or is it coming from the inside? With my patients, there's not much interface debris usually. So at that point, I'm thinking, should I add Tangible Hydra-PEG? Should I change the lens material? Do I need to start them on a drop regimen? Do I need to start blepharitis treatment? Do they need serum tears? Is there a dryness issue?

Those are some of the things that are running through my mind. If it is an interface issue, usually one of the things that I look at is a poor fitting relationship.

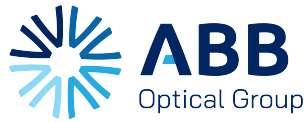
For me, the ICD FLEX lenses are really easy to fit, so I usually don't have a lot of interface issues or debris under the lens. If I see it at all, it's with patients who have goopy eyes to begin with. They put scleral lenses on and mucus or debris may become trapped in that interface. To deal with this issue, we counsel patients to take preservative-free saline and wash their eye out first, before they put their lenses on.

### Craig Norman

Okay. So just as a sideline, you relate to this as the interface issue? Not a common term, but it's very descriptive. There's the lens, the cornea, and then the interface between which is the tear layer where the fogging may be happening.

### Dr. Brown

Yes, it can happen there or on the surface. I don't have to deal with that tear reservoir



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debris very often. My fogging issues usually occur on the surface, and I change materials, add Hydra-PEG, and add lubricating drops which usually solves the issue.

### Dede Reyes

Dr. Brown, during your lecture you talked about the importance of staff training. What role does staff play in your office.

### Dr. Brown

We can see more patients and be more effective if we can work together as a team. I'm not any better than my technicians and vice versa. So, we're a team and we function as a team.

I jump in if they need me to teach an application or removal. They jump in if I need them to get started on a fitting and do the over-refraction. My technicians can essentially do the entire fitting and have me come in the very end to make notes on customizations. My technicians literally know how to do every single step of the process because they're an extension of me, and quite frankly, I need them. I need them to efficiently see patients, and I need my technicians to be knowledgeable. It's beneficial for patients and clinic flow, and it challenges them. The techs appreciate learning a new skill and being able to meaningfully contribute to patient care.

### Craig Norman

You know, if there's a phrase within medicine that the care should be provided at the lowest, most appropriate level. And I think the way that you're describing the use of the staff is exactly that, that there are so many of the different steps in the SOAP examination that can be done through staff and should be. This allows the doctor time to put all of the puzzle pieces together to figure out what's next.

### Dr. Brown

That's right. I've trained hundreds of people, how to refract now. There is an art to refracting and there are times when I must step in, but for the most part, you can train staff to do it. Then, you, as the doctor, can focus on really educating the patient. What I find to be a really important step of the fitting is that application-removal training. I often do trainings myself, because I want to counsel my patients on what solutions to use and how to use them. Sometimes, if it comes from the doctor, patients listen better.

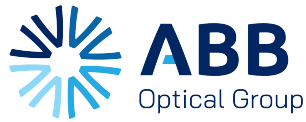
### Craig Norman

I think for sure, during the application and removal, at the very least the doctor sticking their head in the middle of the process to bless everything and answer any particular questions that may be coming up as well. You also mentioned conjunctival prolapse. Do you want to build on that just a little?

### Dr. Brown

With older patients with conjunctivochalasis, you're going to see it. I see it on maybe 50% of people over the age of 50. It happens a lot but is not something you should be afraid of. It generally won't cause Limbal Stem Cell Deficiency or any other issues. It's just something to note, then continue on with your fitting process as you normally would. Dede gave some good points that if the conjunctival prolapse remains and when you move the lens and the eye is getting hyperemic and vascularized you need to consider changing the fit, so that conjunctiva doesn't get sucked up under the limbal zone. But in general, I do not have to make any adjustments for conjunctival prolapse.

### Craig Norman



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You just live with it.

### **Dr. Brown**

We live with it and the patients don't have any issues. They don't experience any discomfort at all.

### **Craig Norman**

For sure it looks a heck of a lot worse than it is.

### **Dr. Brown**

Yes, it does. When I first started fitting, I thought that I was not achieving a proper fit. I thought that I needed to do something different with the fit, but I've learned that you don't.

### **Craig Norman**

Dr. Brown, thanks for your lecture and answering these additional questions.

Thank you, Dede Reyes, for your input as well.