

ESTABLISHING A DRY EYE CENTER OF EXCELLENCE

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These centers can help grow a practice, enhance its reputation, and improve patient satisfaction.

BY JAMES S. LEWIS, MD



Dry eye disease (DED) diagnosis and management now appears to be glamorous. In my opinion, the trade journals, the scholarly publications, “big pharma,” and the device manufacturers have made it clear to many that DED is in fashion. The magnitude of this opportunity should not be underestimated. A dry eye center of excellence can provide significant benefit for afflicted patients and deliver appropriate compensation for the invested practitioner.

Most practices already serve a patient base replete with DED sufferers. Some present with contact lens intolerance, chronic red eye, constant tearing, incessant itching and persistent burning. Many patients will insist they have an ocular allergy and demand a prescription. Others will be dissatisfied with their recent LASIK surgery or complain that their premium IOL procedure was unsuccessful. The reflex is to write a prescription for topical cyclosporin (Restasis; Allergan) or to suggest that patients purchase a bottle of over-the-counter artificial tears. In my experience, these maneuvers will likely be effective in less than 10% of cases. Eye care physicians serious about serving their DED population must invest in the process. With perseverance, a dry eye center of excellence can grow a practice, enhance its reputation, and improve patient satisfaction.

PROPER DIAGNOSIS IS CRUCIAL

Clinical skills will help distinguish the pure cases of aqueous deficiency from those with the more common lipid deficiency disease. Vital dyes, including lissamine green, fluorescein, and rose bengal, are already part of a well-established office practice, and they refine the diagnostic process. Clinical history, a staple of the successful eye care physician, will lead to the correct diagnosis in most cases. Patient surveys, as shown in the professional literature, can aid in DED diagnosis and assessment.

Diagnostic equipment, including devices to measure tear film osmolarity and assays to assess levels of aqueous inflammatory response, help quantify and monitor dry eye disease. The non-invasive Keratograph tear breakup time (NIKBT) developed by Oculus for its Keratograph 5M is the time-tested measurement of tear breakup time. This and other methods to physiologically assess precorneal tears allow practitioners to determine their management choices.

Diagnosis, however, is only the first step in creating a dry eye center of excellence. After the initial visit, patients understand they have DED. While some may want to know if their tear osmolarity has changed, most want an improvement in signs and symptoms. Effective management will drive new patients and enhance satisfaction.

DED TREATMENT AND MANAGEMENT

Oral omega-3 supplements and nutraceuticals are part of a comprehensive management regimen for DED. Judicious use of steroids, prescription tear supplements, and even serum tears can augment the management of this disease. Temporary, semipermanent, and thermal-permanent punctal occlusion can address inadequate aqueous production and help many DED sufferers. These techniques have served practitioners well for more than 3 decades.

Historically, treatment for lipid-deficient DED has been relegated to patient-performed warm compresses, baby shampoo, and lid scrubs. Compliance, in my experience, is usually abysmal, and results are frustrating. Although some blame can be placed on poor technique, warm compresses are only modestly effective. Clinicians have turned to in-office meibomian gland evacuation through lid massage, eyelid margin exfoliation, and manual expression. Options like the use of intense pulsed light hold promise for a select group of patients.

LipiFlow (TearScience) introduced the first FDA-cleared eyelid thermal pulsation therapy designed to address obstructed meibomian secretions. MIBO ThermoFlo (MIBO Medical Group) recently developed a device cleared for use by the FDA. MIBO treats lipid-deficient DED. MIBO precisely transmits controlled warmth through the tarsal plate into the underlying meibomian glands using a patented Peltier process.

MIBO performs an external ocular massage using a variety of contoured silver applanation pads that drive emissive heat and micro-compression to the obstructed glands. Multiple sessions permit a gentle evacuation of the accumulated secretions. Unlike other technology, MIBO has no per-treatment costs to the provider.

MIBO is portable, solid-state, and acceptably priced, making it available to virtually any optometric or ophthalmic practice. Patient pricing can be set at a level palatable to all. MIBO ThermoFlo is an affordable and cost-effective treatment modality for the treatment of lipid-deficient DED.

A successful eye care practitioner willing to invest the time and resources necessary to establish a dry eye center of excellence will be well rewarded. More importantly, his or her patient base will recoup even more substantive benefits. MIBO ThermoFlo represents a powerful foray into this burgeoning field. ■

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