



## Balancing Patient and Practitioner Goals in Contact Lens Fitting

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### Editorial

Patients generally are seeking three things from their contact lens wearing experience, vision, comfort, and convenience. In addition, some individuals will be looking to seek these goals with a minimum of “out of pocket” expense. As an eye care provider our goal in contact lens fitting is to provide for optimal ocular health while also establishing a vision correction modality that maximizes clear binocular vision. However, there may be situations when we need to strike a balance between what patients can and will do, as contrasted with what might otherwise seem the ideal situation.

There is a wealth of published data that clearly indicates that patients do not always replace their lenses with the frequency we would like. Sometimes this is due to negligence, but often the underlying motivation is simply cost. We need to remind ourselves that the replacement period for most contact lenses is not dictated by the FDA, but is based on recommendations made by the manufacturer. The following is taken from the package insert of a commonly prescribed silicone hydrogel lens:

“When prescribed for daily wear (frequent replacement), it is recommended that the lenses be discarded and replaced with a new lens every 2 weeks. However, the Eye Care Professional is encouraged to determine an appropriate replacement schedule based upon the response of the patient.”

Should a patient, based on other factors such as the need for higher oxygen transmissibility and or optical factors, be best suited for such a lens but also express some economic constraints, my approach is to “meet the patient halfway”. What I might present to the patient is the option of considering this lens for monthly replacement, provided they are compliant with daily digital cleaning and appropriate lens

disinfection protocols. I would in this case schedule the patient to return at a point nearing the end of one month’s period of wear, to ensure that there is no compromise to either corneal or palpebral tissue. If the patient reports good comfort and vision, and there is no evidence of adverse effect to corneal or palpebral tissue, I would educate the patient to continue with monthly lens replacement.

I have often made similar compromises regarding our goal as an eye care practitioner of providing the best possible binocular visual acuity. There is ample evidence that multifocal lenses would in general be preferred over monovision in the correction of presbyopia. However, here too exceptions may exist. Without exception all simultaneous vision multifocal lenses are by design pupil dependent. That translates into a modality that is also going to be influenced by ambient lighting. For individuals who need both optimal distance and near vision in a variety of lighting conditions (ie: a college professor who needs to both see his notes and recognize student faces when alternating between slide presentations in dim illumination and verbal discussions in normal room lighting), I have often presented the patient with monovision, accepting the loss of stereopsis for the clarity of vision under varying lighting conditions. Although this approach is not universally accepted, it deserves consideration when a patient is unable to achieve their visual demands using currently available soft lens multifocal designs.

Clearly this represents but two examples of where a compromise to may prove advantageous in meeting patient needs versus what is ideal. However success starts with a good history, to ensure that we achieve the patient’s goals for contact lens use. Patient adherence to our recommendations can only be optimal when we consider not only our goals as eye care providers, but the aspirations as well as limitations imposed by the patient themselves.