



PRESBYOPIC PERSPECTIVES

A check-in with clinicians who regularly treat this sometimes-temperamental patient population.

A ROUNDTABLE WITH SELINA R. MCGEE, OD, FAAO; MARGARET MOORE, OD, FAAO;

JERRY ROBBERN, OD; NOA ROBSON, OD, MBA; AND JUSTIN SCHWEITZER, OD, FAAO

With the growing number of management options for presbyopia, practitioners can perhaps feel more confident when preparing to face patients dealing with the age-related refractive error. What are some of the seasoned eye care practitioners in the field reaching for when prescribing a treatment for their presbyopic patients? How has their management strategy changed? What are their thoughts on patient education needs? *Modern Optometry* (MOD) put a panel of experienced and newer thought leaders together to get their perspectives on these and other questions.

MOD: What do you find most rewarding about treating patients with presbyopia?



Jerry Robben, OD: Helping them solve real-world problems in ways that work for their lifestyle, helping them understand how and why presbyopia happens, and what to expect as time goes on.



Noa Robson, OD, MBA: Treating patients with presbyopia is so rewarding—especially these, as there are an extensive number of options available for enhancing their near vision—not just the typical OTC readers most patients reach for.



Selina R. McGee, OD, FAAO: I love this patient demographic because there are so many nuances to our conversations. There's a lot of psychology at play in this age group, and being presbyopic myself, I relate to it very well. I get to problem-solve with my patients and build a relationship with them as they go through the presbyopia journey. I'm able to relate, offer a trusted partner who has their back through it all, and be a source of information.



Margaret Moore, OD, FAAO: Solving their challenges, especially for task-specific demands such as reading and playing music.



Justin Schweitzer, OD, FAAO: The available options (eg, spectacle lenses, contacts lenses, pharmaceutical agents, refractive surgery options, and IOL options) have become so much more innovative and are able to achieve the goals of many patients with presbyopia.

MOD: When do the majority of your patients develop presbyopia? Are you seeing any trends toward earlier development?

Dr. McGee: I see patients who hit presbyopia at different ages, but because our visual demands are so different and so high, they do seem to be developing presbyopia younger, on average.

Dr. Moore: Most of my patients seem to become symptomatic between 45 to 50 years of age, but it depends on their day-to-day routine and visual demands. In the era of smartphones, it's likely that new presbyopes are noticing blur at near sooner than they would have otherwise. However, I haven't found an updated study regarding presbyopia onset, and

it would be interesting to compare modern data with past studies.

Dr. Robben: We all know that a lot of patients try to hold out until they can't function well. Some surprise me with how far into their 40s they get before they really require presbyopic correction. Others need it before they hit 40. For many patients, near vision changes are what bring them to an optometrist for the first time. The key is proactively educating patients who are approaching their 4th decade of life to let them know what to expect and that we have solutions for them when presbyopia first emerges, not only for when they are struggling.

Dr. Schweitzer: Each person has different needs and capabilities. For example, I have 50-year-old patients who should be struggling with near-vision tasks but get by just fine with minimal use of aids. On the flip side, I have patients who are in their 40s and already struggling with near-point tasks.

Dr. Robson: Many of my patients are right around that 45-year-old mark when they start experiencing the effects of presbyopia, although I start asking them about their near vision around age 40. Presbyopia, like cataracts, is inevitable, and I find that planting the seed is the best first step.

MOD: How has your management of patients with presbyopia changed in the past 10 or so years?

Dr. Schweitzer: Innovations in IOL technology have allowed me to offer this option more often now than ever. I also now educate on pharmaceutical options that did not exist 10 years ago.

Dr. McGee: It's totally different. I'm much more proactive in how I talk about this. I talk to them about presbyopia well before it happens so patients know what to expect. I also ask pointed questions about lifestyles

and hobbies. Knowing how they use their vision is important so that you can offer customized solutions with the technology we have at our disposal. It is from an educational and therapeutic standpoint that we can make the biggest difference.

Dr. Robson: Although spectacles will likely remain the dominant management option, contact lenses and pharmacologic treatments have a great deal to offer to many patients. I find myself no longer thinking of glasses correction as the primary option and instead treat each patient as an individual case to discuss the options best



suited for them. I have also found that many contact lens wearers stop wearing their lenses once presbyopia hits—as if they are simply unaware of all the contact lens options available to them.

Dr. Moore: I've been in eye care since 2012, and it's been an interesting time to see the treatment options expand so rapidly, between different contact lenses and IOLs to improvements in progressive addition lens design and now to topical treatment for presbyopia. With the increasing number of treatment options, it's been more important to thoroughly interview patients about their visual demands for their work and hobbies

and determine what options are best for them, as presbyopia treatment has increasingly moved away from a one-size-fits-all algorithm.

Dr. Robben: I prescribe more computer and/or workstation glasses. Patients love these! We also now have presbyopic medications at our disposal and more in the pipeline that are promising. Additionally, surgical approaches have come a long way with refractive lens exchange. We are having great results with traditional cataract and clear lens surgical candidates receiving the Light Adjustable Lens (RxSight). They are achieving an excellent postoperative range in vision.

MOD: How much education about presbyopia is needed in your patient base?

Dr. Robson: It depends on the individual. Patients who are in denial are those who have had prior refractive surgical correction and now feel they must go back to wearing glasses all the time, as well as emmetropic patients who have never needed any form of vision correction. Patients who have worn glasses consistently seem to accept the news more easily, as the change is minimal for them.

Dr. Moore: I discuss presbyopia with patients before it happens—just after their 40th birthday—so it doesn't come as a surprise and cause them to wonder if they're experiencing pathology. It's also important to remind patients with emerging presbyopia that their need for near correction will increase slowly every few years before leveling off around age 65.

Dr. Robben: Most patients know vision changes with age, but they may not notice when it happens to them. The inevitability of change and options we can offer is a good talking point.

FUTURE INSIGHTS

We asked the panel what they think the future of presbyopia treatment will look like. Below are their responses.

Selina R. McGee, OD, FAAO: I believe we're going to get more comfortable with all our options, including combination therapy, and candidacy requirements for each.

Jerry Robben, OD: I think medications and surgical options will become more mainstream. Bifocal glasses were invented by Benjamin Franklin more than 300 years ago. Sure, the progressive lenses of today are very advanced, but I think we have squeezed that orange about as much as we can. It's time to look for what is next.

Margaret Moore, OD: I hope to see wider availability of surgical options for pre-cataract presbyopia correction in the future. Presbyopia treatment will include an increasing number of options and thus provide an increased potential for customization to tailor each patient's management to their unique needs.

Justin Schweitzer, OD, FAAO: Many pharmaceutical options are in the pipeline and show promise. I also believe IOL technology will continue to evolve, specifically IOLs that have the ability to accommodate.

Noa Robson, OD, MBA: Pharmacologic correction for presbyopia is on the rise, as many patients are interested in a noninvasive approach to visual correction. The mechanism behind these drops constricts the pupil and increases the depth of field, known as the "pinhole effect." Although these drops only work well for moderate presbyopia, I am hopeful for other pharmacologic advances that are on the horizon.

Dr. Schweitzer: Education is always necessary. Many patients are aware of presbyopia, but so many myths about it exist. Much of the education needs to be around the treatment options that are available, including contact lenses, spectacle lenses, IOLs, refractive surgery, and pharmaceuticals.

MOD: What is your typical approach to managing patients with presbyopia?

Dr. Moore: I like to present all available options so patients don't hear

elsewhere about a treatment I didn't offer. I then follow this list with what I feel is the best option or options for them. Presbyopia treatment isn't one-size-fits-all, given the many different visual demands that different occupations and hobbies require.

Dr. Robben: Of course, I always start with an appropriate glasses prescription, but we also discuss other management methods, such as contact lenses, prescription medications,

and even surgery, when applicable, so patients know that they have options besides glasses, and what they are. That initial conversation and where that leads helps guide management.

Dr. Robson: I believe it's our responsibility as providers to stay updated on new advances in the field to ensure we are offering our patients the best care possible. Each patient deserves an individualized approach. Also, don't be afraid to combine two treatment options for optimal success. For example, if a patient is not satisfied with their near vision in multifocal lenses, have them instill a pharmacologic drop for presbyopia prior to contact lens insertion to determine if near vision clarity improves.

Dr. Schweitzer: I tend to lean towards contact lenses, spectacle lenses, pharmaceuticals, and refractive surgery for the early presbyope or the presbyope who is not symptomatic all the time. As a patient ages, and becomes more symptomatic, refractive lens exchange and IOLs slide to the top of my list.

MOD: Is there anything else you would like to add about your experience treating patients with presbyopia?

Dr. Robson: Early patient education and keeping an individualized approach are key to presbyopic treatment management. Our duty as eye care providers is to be aware of the pros and cons of various treatment options and help select and inform the best option for each patient. It is also critical to keep in mind that some patients may require multiple forms of presbyopic treatments for varying tasks, activities, and circumstances in their daily lives.

Dr. Moore: Presbyopia is a condition that everyone will develop if they're lucky to live long enough! The management of presbyopia, which affects over one billion people in the

world, often stands between patients and their ability to earn a living. We're very fortunate in the United States to have multiple options available to correct presbyopia, and it's important that eye doctors make these options available to their patients.

Dr. McGee: Doctors must remember that this age group is when you can really make a difference because these patients tend to have children, so we should also be bringing up myopia management and visual hygiene, and it's also when patients typically start to struggle with dry eye disease and find that things start to go awry systemically. You can really start to educate and do some prevention. Remind patients that we can see diseases such as diabetes, high blood pressure, and high cholesterol, which is why an eye exam should be part of

their every year health exam—because it's not just about vision. ■

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