

DRY EYE DISEASE IN THE REAL WORLD

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In the world of dry eye disease, eye care providers are faced with many challenges to maximize our abilities to treat our patients. We find ourselves sorting out the technology and tools for measurements and treatments, and getting staff and physicians on board to recognize and treat chronic dry eye. The patients themselves frequently add to the challenge. For example, I regularly experience patients where every single test I offer points to an abnormal ocular surface, yet the patient's response is, "but my eyes don't feel dry." In this article, I will share some of my pearls that I have found effective in convincing a patient who may be in denial, that they have the condition, along with the reasoning behind treatment recommendations.

So many times, patients come in with something different on their mind from dry eyes. A diabetic patient is there to full fill their needed diabetic eye exam, A contact lens patient is there just to get their contacts, A cataract patient has scheduled a time to talk about surgery. Many of these patients, including surgical patients, often don't have noticeable symptoms of dry eye disease at the time of your exam. In these cases, it is especially important to make metrics, such as tear osmolarity, mmp-9, meibography and lipid layer thickness testing, as standard pre-operative measurements, especially in your surgical patients. Otherwise, be prepared to discuss how their surgery went perfect, but they have dry eyes, and they had dry eye before your surgery. And now their dry eye is causing their fluctuating vision postoperatively, but you never said anything about the dry eye before the surgery. This will be a patient who will forever

think that their cataract surgery, done by you, caused their dry eye disease. I always recommend to have a significant conversation with your surgical patient regarding the results of their dry eye testing before surgery; as well as, what dry eye frequently presents as after surgery. Based on your assessment of the patient and their metrics it is also important to start appropriate dry eye treatments, as soon as possible, before the planned surgery. It's important to make this a more lengthy and memorable conversation, not a quick side note. Most patients won't remember a brief dry eye discussion as they are being immersed in the testing and preparation for surgery. We must ensure that the patient understands the dry eye discussion just as well as the surgical discussion.

Often, I have a patient come in who don't want an eye exam, they just want a bump on their lid removed, such as a chalazion. These patients do not feel that they have an eye problem, but just a benign bump on their lid, therefore they do not understand why we need to examine them. For these patients, meibography and appropriate patient education become extremely important to help the patients visualize the effect of a chalazion on the meibomian glands, (permanent destruction) and the risk of further atrophy, possible additional chalazions over time and chronic progressive dry eye disease. I show them and discuss extensively how a chalazion can be treated and/or removed, however without proper treatment, it can and often will return because of the state of the eyelid environment that has caused it in the first place. In addition, we discuss how we only have one set of meibomian glands for our entire life, and with inflammation and obstruction

causing this type of destruction, it is just a matter of time before they have fewer oil glands, which means less oil in the tear film, faster evaporation of tears, and then they won't be able to stare at their phones or computer comfortably (which is also a major contributing factor). Additional dry eye metrics such as tear osmolarity, lipid layer thickness and mmp-9 can help me to educate the patient in full. I discuss how there are patients who have zero remaining oil glands who often relate a history of having styes or chalazions in the past. We discuss how this can lead to more time and effort treating dry eyes in the future with less success. It is important to emphasize the prevention aspect of dry eye disease for these patients and try to paint a picture of how their dry eye future might be without the prevention.

There are many examples of patients who won't believe that they have dry eye disease. They are in your clinic every day looking at the variations of meibomian glands or hearing the devastating effects that dry eyes have on other patients, but they don't that that "they" have a problem. One of the most effective statements I make to patients to help convince them of the need

for treatment is that 'it's crazy to think that our eyes can make the normal amount of tears and oils every day for the rest of our lives with the amount of stress that we put on our eyes.' We discuss how imbalances are inevitable, and mainly that there is silent damage to the meibomian glands and the ocular surface from our environment, allergies, biofilm, autoimmune disease, lifestyles, medications, makeup use, skin types such as rosacea, and many other factors. It is essential to emphasize to patients that there are treatments available that can help nurture the remaining meibomian glands to prevent or reduce their progressive damage and improve the health and quality of their ocular surface. It is essential to instill in these patients that they have a chronic disease that requires consistent treatment and follow up. I follow up regularly with my dry eye patient, typically every 3 months to monitor ocular surface disease in controlled patients and more frequently as we are beginning treatment or if they are considered not controlled. Because above all, if the physician takes this disease seriously, I find the patients are more likely to do so as well.