

International Panel of Experts Advocate for Global Awareness of Myopia as a Disease

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Over the past several years, the science of myopia control and management has rapidly advanced, with considerable support and advocacy from CooperVision. The company has historically partnered with optometrists to pursue relevant research and evolve clinical practice, and is also collaborating with ophthalmology to broaden understanding, discussion, and action on this critical public health issue. In that spirit, CooperVision commissioned a panel of leading ophthalmologists to share insights with their peers through this white paper.

The days of pediatric ophthalmologists only prescribing single-vision spectacles and single-vision contact lenses for myopia correction are rapidly fading in the rearview mirror. Treating myopia and minimizing its progression with interventions may soon become the new standard of care for all eye care professionals (ECPs), driven by the mindset that the effects of visual impairment in adulthood may be minimized by managing myopia in childhood. The efficacy and safety of today's myopia treatment interventions are encouraging all ECPs to offer myopia management (MM) to a wide age range of patients. Here, an international panel of ophthalmologists present their perspectives on MM in clinical practice and their recommendations on advocacy for managing myopia.

Myopia progression needs to be treated and controlled, not just corrected for clear vision.

“MM is analogous to planting a tree today, knowing you will not enjoy its shade of tomorrow,” Benjamin R. LaHood, MD, said. “In other words, we put in the hard work of minimizing myopia today without seeing the fruit of our labor later, which is fewer long-term myopic complications.”

Critical Need in Myopia

Myopia is considered a worldwide public health crisis because of its drastically increasing prevalence.¹ Its global prevalence is estimated to reach 50% of the population by 2050 without intervention.² Increased prevalence is primarily attributed to lifestyle changes, including increased near work and decreased outdoor time.² In the United States, the socioeconomic impact is estimated at \$244 billion from uncorrected myopia and at \$6 billion from myopic macular degeneration (MMD).³ Myopia is associated with complications including open-angle glaucoma, retinal detachment, posterior subcapsular cataract and myopic maculopathy (ie, MMD), that can lead to permanent visual loss.⁴ A 2020 systematic review and meta-analysis by Haarman and colleagues determined that patients with all levels of myopia are at an increased risk for these complications.⁴ Therefore, a critical need exists worldwide to lessen the prevalence and severity of myopia, with the purpose of minimizing myopic vision loss in all populations.

Evolving Perspective

Historically, myopia has only been managed optically with spectacle lenses, contact lenses and refractive surgery, all of which temporarily provide clear vision.^{4,5} Within the last decade, minimizing myopia’s detrimental effects by delaying its onset and slowing its progression has received heightened interest because of the increasing prevalence and risk of visual loss associated with myopia.⁶ Recent development of several novel therapies for MM has led to these therapies becoming a more common treatment for pediatric patients with myopia than single vision lenses alone. “We have the ability to treat myopia early with interventions as opposed to treating myopia once it turns pathologic,” Rupa K. Wong, MD, said. Interventions in MM include those that are behavioral, pharmacologic, such as topical atropine eye drops, and those that are optical, such as MM spectacle lenses and contact lenses. “We owe it to our patients to not only help them see clearly but also to minimize their final myopia,” Christie L. Morse, MD, said.

With the availability, effectiveness and safety of its interventions, MM is becoming the standard of care for pediatric patients with myopia. Its goal is to keep patients in the lower range of myopia especially during their growing years, to lessen their risk of vision loss from myopia pathology.⁷ Therefore, pediatric ophthalmologists are shifting their viewpoint of myopia as an inconvenient symptom to a manageable disease. “All diseases have risk factors that we attempt to modify,” Imran Jawaid, MD, said. “Because MMD is a disease, ECPs should modify its risk factor of higher myopia by slowing the progression.”

Current State of MM in Eyecare

The International Myopia Institute (IMI), formed in 2015 with a global group of myopia experts, is also focusing its attention on MM. They are a leading source of MM education for ECPs, scientists, policy makers, government officials and the general public, by freely offering detailed, peer-reviewed white papers that contain updated information on myopia, including its prevalence, risk factors and clinical trial results. These papers also provide ophthalmologists with global models of eye care in collaboration with optometrists and other stakeholders to aid in management strategies.

To elevate its focus on MM within the ophthalmology community, the American Academy of Ophthalmology (AAO) created the 2019 Myopia Task Force.⁸ A primary goal was to determine how the AAO could assist in being a resource for MM.⁷ The Task Force also aimed to transition the concept among the public and health care community of myopia as a “routine” condition to a condition with risk of long-term complications.⁸ The AAO has also undertaken educational efforts at the national level through press releases and media exposure for the public and medical community. At the local level, the AAO has developed toolkits to aid in educating individual practices and ECPs.

Slow Adoption

Despite the wealth of evidence on the benefits of MM, many ophthalmologists are not yet prescribing evidence-based treatments. Foremost, many seasoned ophthalmologists were not trained to classify myopia as a disease with treatment options other than correcting refractive error. They were trained to treat patients with higher levels of myopia and those at higher risk for complications. Conversely, MM embraces treating pediatric patients with any amount of myopia early. Therefore, the concept of managing myopia, particularly low myopia, can be difficult to accept, and it requires time and a shift in mindset.

The American Academy of Ophthalmology (AAO) created the Myopia Task Force in 2019.

“It’s human nature to need to hear something over and over before acting,” K. David Epley, MD, said. “I think MM is beginning to become a groundswell, and more and more ECPs are adopting MM as an acceptable practice, although we still have a long way to go.”

“Another reason is the misconception that the goal of MM is to avoid high myopia,” Francisco Javier Hurtado Ceña, MD, said. However, every diopter of myopia can affect the daily life of a patient, such as their dependence on spectacles, and their future eligibility for refractive surgery.⁹ Furthermore, ophthalmologists and patients often have different perceptions of high myopia, Jawaid said. “Ophthalmologists define high myopia by the level of risk for myopic complications,” he said. “However, patients view high myopia subjectively. To a patient, is high myopia the fact that they can’t see their clock in the morning? Or is high myopia the fact that they can’t watch TV or go to a cinema and watch a movie without their spectacles?” Therefore, both the clinical and the patient perspectives are important to consider when determining whether MM is an appropriate treatment for an individual patient.

Some ophthalmologists do not offer MM because of the notion that its cost will deter the patient. “Deciding that a patient will decline a treatment without educating them is making a decision for the patient,” Wong said. “I let my pediatric ophthalmology colleagues know that they should educate patients on their treatment options and let patients and their guardians decide whether MM is a treatment that they want to pursue.”

Slow adoption of MM is also due to limitations in the practicing rules of ophthalmologists and optometrists or in the health care system itself, particularly in countries outside of the United States, including Spain, Hurtado Ceña said. Restrictions can limit one’s scope of practice or access to the medical treatments, including contact lenses and pharmaceutical agents. Medical insurance issues are another perceived barrier for ophthalmologists. This hurdle may be lowered by creating a patient informational packet or folder containing treatment and compounding pharmacy options that the patient can address with their insurance company.

Additionally, general ophthalmologists may have an incomplete view on the use of contact lenses in children, and they may hold onto the outdated belief that contact lenses are not safe for children. A 2020 study by Gifford and colleagues compared the immediate risk of contact lens wear with the long-term risk of vision impairment from myopia.⁹ The study found that the lifetime risk of vision impairment in myopia greater than 6D and in axial lengths more than 26 mm is much greater than the lifetime risk for infectious keratitis with any contact lens modality, except for adult soft contact lens extended wear (Figure 1).⁹ Furthermore, the risk-to-benefit balance of only childhood contact lens wear was skewed toward the positive impacts of contact lens wear, particularly daily disposable lenses.⁹ Last, the study determined that the comparative lifetime risks of contact lens wear in children beginning at age 8 for MM are less than the lifetime risk of vision impairment from myopia pathology in myopia greater than 3 D or in axial lengths more than 26mm.⁹ “Understanding that optical interventions, like single-vision spectacles or contact lenses, are safe and relatively low risk should help ophthalmologists feel confident in prescribing myopia controlling spectacles and contact lens treatments for MM,”

Jawaid said.

Other reasons for slow adoption of MM by ophthalmologists include a lack of publicly available guidelines and the practice logistics of incorporating MM. “Despite the resources offered by the AAO and IMI, myopia management lacks a consensus protocol,” Jawaid said. “The IMI clinical practice guidelines sub-report is a great resource. Additionally, The Royal College of Ophthalmologists and the College of Optometrists in the United Kingdom have made considerable efforts towards developing their own consensus guidelines for MM.” The practice logistics of MM is often viewed as a major hurdle for many ophthalmologists. Chair time is a major concern, particularly when pediatric ophthalmologists are exceedingly booked with patients already. However, where available, treating with atropine may be a simple first step to dive into MM. “Low-dose atropine gets an ECP’s foot in the door for MM. It is safe and effective with a simple dosing schedule,” Robert A. Clark, MD, said. Still, ophthalmologists should consider all appropriate interventions that are available for their patients and acknowledge that the need for vision correction remains with the use of atropine.

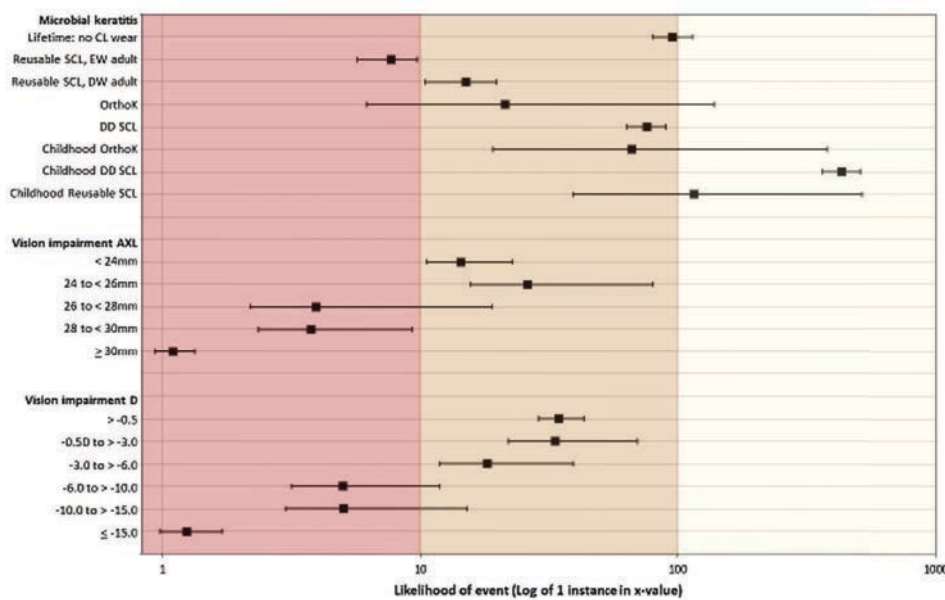


Figure 1. Likelihood of each ocular health event occurring once per individual over a lifetime, except for three childhood microbial keratitis risks as indicated.⁹ The 95% confidence intervals are presented on a Log scale. The WHO CIOMS classification system for frequency of adverse events¹⁰ is indicated by colored shading: red, very common (more than 1/10); orange, common/frequent (between 1/10 and 1/100); and yellow, uncommon/infrequent (between 1/100 and 1/1000).

Abbreviations: AXL, axial length; CL, contact lens; D=diopeters; DD, daily disposable; DW, daily wear; EW, extended wear; SCL, soft contact lens.⁹ (Reprint permission from Contact Lens Anterior Eye)

To educate the public, national awareness programs may be effective in schools to educate children and their teachers.

Overcoming the Time Barrier

From a practice management perspective, the greatest barrier to MM is the time commitment to educate patients, parents, the public and other health care professionals. “I think that education is key to reducing chair time,” Li Lian Foo, MD, said. Having a properly trained staff and partnering with optometrists can streamline MM, making it financially productive. Staff can educate patients and their families in the office with detailed conversations, pamphlets or folders, and videos. They can train patients on how to apply and remove contact lenses, and optometrists can fit contact lenses and, in some countries, also prescribe low-dose atropine. Outside of the office, patients can access recommended online educational resources to learn more about the safety, efficacy, and need for MM. To educate the public, national awareness programs may be effective in schools to educate children and their teachers. Public webinars can educate parents, as well as children. National eye care websites and social media are particularly effective educational tools. “Right now, short video content is key,” Wong said. “For example, post a video that includes the top three tips to keep nearsightedness at bay.” Chatbots that answer a parent’s questions on MM are also a great tool to educate the public.

A focused effort on educating other health care professionals is also essential to decreasing the time commitment of MM for ophthalmologists. Primary care providers, school nurses and trained service organizations perform vision screenings on many children and thus need education on MM. “Children and parents love their school nurses, and often these nurses are the ones to first identify vision issues and refer the child to an ECP for an examination,” Morse said. “It is therefore beneficial for nurses, in addition to pediatricians and family practitioners, to know about MM options. We need to get the message out to a variety of health care professionals, so that we have the opportunity to help more children.” To inform health care professionals on a large scale, sending a letter or holding a state chapter seminar on MM is an effective strategy. “I sent out a letter to every pediatrician in my state that detailed when to screen children, which treatment options are available to manage myopia, and where to access additional resources,” Wong said.

Practice Considerations

Collaboration between ophthalmologists and optometrists has many benefits.¹⁰ Whether that comes in the form of establishing referral patterns or co-management relationships with trusted peers in the community or collaborating on MM patient care within the same office, ophthalmologists and optometrists increasingly work together to manage patients with myopia. And eye care staff often play a critical role as well.

Involving the entire staff in the patient experience can also optimize practice resources. “Patients have their follow-up appointment with the optician or contact lens specialist,” Clark said. “My part in the follow-up appointment is to perform retinoscopy to see if the patient needs an adjustment in lens power or atropine dosage. So, I spend a couple of minutes only, taking little of my chair time.”

Some ophthalmologists are concerned about adding myopia management to their offerings because of chair time. The fitting and evaluation fees for MM contact lenses, set by the practice, should compensate for the extra chair time required to educate patients and parents. Interestingly, most practices in the United States charge the same price for all MM contact lens fittings, although some fittings, such as for orthokeratology (ortho-k), can be more time-intensive and challenging. At many practices, the initial global management fee includes the contact lens fitting, all patient visits for the upcoming year,

and application and removal training. The subsequent yearly evaluation fee is typically in addition to a comprehensive examination; however, this fee is typically less than the initial year one fee.

Ophthalmologists and optometrists increasingly work together to manage patients with myopia.

Interventions in MM

Today's interventions in MM include those that are pharmacologic, optical and behavioral. Studies on topical atropine in high doses (0.5%-1%) have shown a slowing of myopia progression with treatment, but its mechanism of action is not yet fully understood.^{11,12} However, high-dose atropine can have limited practicality because of its adverse events of photophobia and blurred near vision – it also has a rebound effect upon discontinuation.¹³ More recently, the Low-Concentration Atropine for Myopia Progression, or LAMP, study examined the effect of lower doses of atropine (0.01%- 0.1%) on reducing myopia progression.¹⁴ This study found that lower doses of atropine have a positive treatment effect on refractive error changes, although not as large as higher doses, and was well tolerated.¹⁴ Notably, axial length elongation in the 0.01% atropine group, despite the slowing of refractive error changes, was not significantly reduced compared with the placebo group.¹⁴ However, to date, atropine is not approved by the U.S. Food and Drug Administration (FDA) for MM. Regulatory approvals and prescribing vary by country.

Optical treatments include spectacle lenses and contact lenses that are designed to slow myopia progression. Spectacle lenses are an option for patients who are clinically unsuitable or for those whose parents decline pharmacological and contact lens options. The latest spectacle lenses incorporate unique designs that simultaneously correct refractive error and impose myopic defocus, which is thought to slow axial elongation.¹⁵ To date, no spectacle lenses are FDA approved for MM in the United States. In countries outside of the United States, evidence-based MM spectacle lenses are available. These include MiYOSMART with Defocus Incorporated Multiple Segments Technology (Hoya Lens), and Stellest™ with Highly Aspheric Lenslet Target Technology (Essilor). SightGlass Vision™ with Diffusion Optics Technology™ (SightGlass Vision), offers a novel optical design that tackles myopia progression by slightly reducing contrast, which is achieved by incorporating thousands of micro-diffusers. Clinical trial evidence suggests that these lenses significantly slowed myopia progression within the evaluated patient cohorts and ethnicities.¹⁶⁻¹⁸ Other spectacle lenses like Progressive Addition Lenses, bifocals, and low plus readers have clinically insignificant treatment effects and should be avoided when MM is the sole aim of treatment.

Contact lens options for MM have been available for varying lengths of time. For the US, these include ortho-k, and soft multifocals for presbyopes being used off-label by ECPs for myopia management, and soft dual focus for myopia control. Ortho-k lenses, such as the Corneal Refractive Therapy. (CRT, CooperVision Specialty EyeCare) and Vision Shaping Treatment™ (VST, Bausch + Lomb) lenses temporarily reshape the cornea during nighttime wear, which lessens the amount of myopia and allows patients freedom from visual correction during the day.⁸ Safety is a minimal concern with an annual incidence of 4.9 to 13.9 in 10,000 patient years for microbial keratitis in children.^{19,20} Also, fitting ortho-k may require additional expertise and is well supported by manufacturers providing technical support and online tools.

Some soft contact lenses have similar efficacy to ortho-k, yet they involve less training.⁸ Lenses indicated for MM with regulatory approvals in various countries include the dual focus MiSight® 1 day (omafilcon A, CooperVision) in over 30 countries including the

The latest spectacle lenses incorporate unique designs that simultaneously correct refractive error and impose myopic defocus or reduce contrast to slow axial elongation.

United States* and NaturalVue. (VTI) and Mylo (mark'envoy) in Europe. In November 2019, the MiSight® 1 day contact lens became the first and only FDA approved medical device indicated to slow the progression of myopia in children aged 8 to 12 years at the initiation of treatment.^{21*} It also gained approval by the Chinese National Medical Products Administration in August 2021. To date, the MiSight® 1 day lens remains the only medical device in the U.S. and China markets with a myopia control indication.^{21*}

Last, myopia onset may be delayed and progression may be slowed with behavioral interventions.²² These behavioral modifications include increasing outdoor time and lessening extended time spent on near-work, including school work and the use of digital devices. Some studies suggest that outdoor time may slow myopia progression, although evidence is minimal.⁸ However, outdoor time does appear to delay or prevent the onset of myopia, which may lessen the amount of final myopia seen at ocular maturation in adulthood.⁸ Increased working distance may also slow myopia progression, but the practicality of this modification may be difficult to enforce with a smaller effect size.¹⁵

Limitations

Current treatment options have various limitations. Low-dose atropine lacks evidence of its effectiveness in certain age ranges and it must be used as an off-label treatment in children of all ages in the U.S.²³ Some patients are also non-responders or have an intolerance to atropine.²⁴ Ortho-k lenses are generally able to only correct myopia up to -6.00 D and astigmatism up to -2.50 D, limiting their use in candidates with higher refractive error. The MiSight® 1 day contact lens is available up to -7.00 D in the United States and -10.00 in most other countries where it's available.^{25*} "A main benefit of MM for patients with high refractive errors, such as -8.00D or -9.00D, is to reduce the chance of them reaching even higher refractive errors that limit options for refractive surgery," Epley said. Because of these limitations, MM modalities need to continually advance to encompass a broader, more comprehensive range of options. Additionally, adherence to recommended wearing times can also pose a limitation and cause a significant reduction in effectiveness if spectacle options are not worn full time, since the commitment to treatment needs to be full time and for a long time.

Best Practices in MM

The clinical protocol of ECPs experienced in MM has evolved and changed over the last several years because of the increasing number of patients with myopia and the safe and effective treatment options. Many ophthalmologists have changed their MM protocol, starting treatment at an earlier age and continuing it through older ages, up to 18 years of age and beyond in certain instances. "MM treatments, such as the MiSight® 1 day contact lens, have been successful in minimizing myopia in many of my patients," Ceña said. "Managing progressive myopia in pediatric patients is even more critical today because the lifestyle of many children now centers around a great number of indoor activities, such as viewing tablets and video games, which can contribute to the increasing prevalence of myopia and high myopia.² Furthermore, we should focus our efforts on children because we can slow myopic progression by a greater amount in childhood, not adulthood."³⁴

Minimizing myopia at a young age is also important to reduce the likelihood of higher myopia according to the 2016 research article by Chua and colleagues.³⁵ The study investigators found that the onset of myopia at an earlier age or a longer duration of myopia

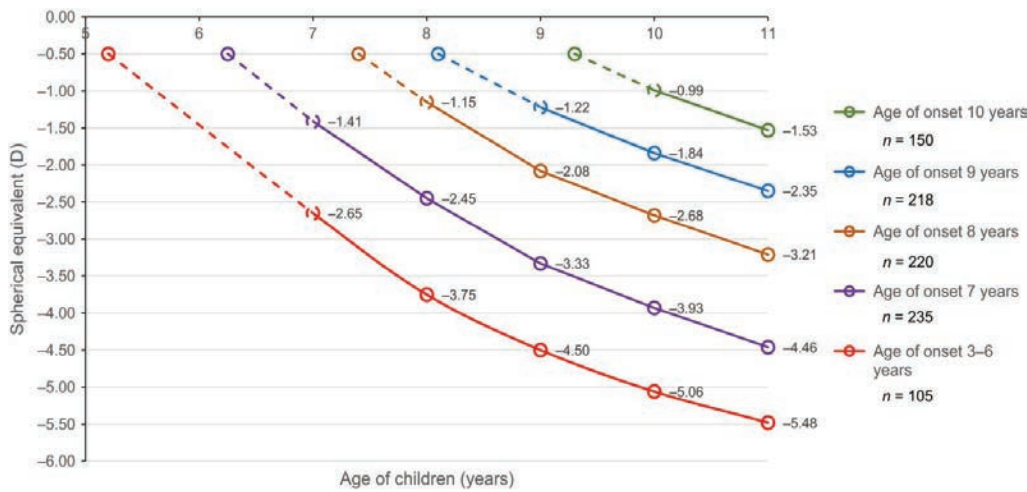


Figure 3. Yearly changes in spherical equivalent (D) of children with myopia from 7 to 11 years of age, stratified by age of myopia onset (n = 928). D, diopters.³⁵

progression is significantly associated with higher myopia at 11 years of age (Figure 3).³⁵ Also, initiating myopia treatment with low-dose atropine in a young patient can increase the patient’s acceptance of MM contact lenses in the future. “Using atropine eye drops is an easier first hurdle for compliance than contact lenses,” Clark said. “Therefore, we start patients aged 5 to 7 years on low-dose atropine. These patients get used to putting something in their eye for 1 to 2 years, and when they are 8 or 9 years old, their transition to a contact lens is easier.”

Furthermore, “although atropine is effective at minimizing myopia, it is not a tangible treatment,” LaHood said. “Parents and children do not ‘see’ the results of atropine. However, contact lenses and spectacle lenses are tangible treatments, creating an emotional component to therapy.” MM may be initiated in children with any amount of myopia, starting at $-0.25D$. “The sooner we start MM in a child, the more myopic diopters we avoid. The risk of irreversible visual damage increases with each diopter and any degree of myopia increases this risk,” Ceña said. This approach is based on the 2019 article by Bullimore and colleagues that found every 1D less of myopia progression decreases the risk for developing myopic maculopathy by 40%, regardless of the level of myopia.³⁶ Also, a “best candidate” for MM does not truly exist today because practically every child with myopia will experience progression. “Furthermore, it is quite rare to have a patient who is unable to adapt to any of the multitude of today’s MM treatment options,” Ceña said. Ophthalmologists of today can prescribe one or more types of myopic treatment to most patients.

Combination treatment, which is an off-label approach, is an effective management strategy to minimize myopia in certain patients. A 2022 systematic review and meta-analysis of 19 randomized controlled trials found that atropine (0.01%-1%), ortho-K, and 0.01% atropine combined with ortho-K all significantly slowed myopia progression.²⁶ Efficacy for minimizing myopia with atropine showed a dose related pattern.³⁷ Finally, combining low-dose atropine and ortho-k had similar efficacy in lessening axial elongation as high-dose efficacy.³⁷ “I use combination treatment as soon as possible in children with a high risk for progression,” Ceña said.

Importantly, patients and their caregivers need detailed and comprehensive education on MM to make an informed decision. The consultation must set clear goals for the patient, and the parent must know that MM may well slow but does not stop the progression. Parents must understand that treating myopia lasts through childhood, not a few months. They also must understand that MM is treating a condition in the present to lessen the chance of poor visual and eye health outcomes in the future. To date, no head-to-head

studies exist that compare one treatment intervention to another. Therefore, selecting the best treatment is patient dependent. “We have careful discussions with parents and patients on what we are trying to achieve,” Jawaid said. “We are attempting to slow, not stop, progression. No treatment is 100% effective at slowing myopic progression.” A simple and strong message is necessary on treatment options with details in which the parents are interested. “State the treatment options and explain why a particular option is best for the child,” Ceña said.

Advocacy and Future Support

In the United States, the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) held a strategic planning meeting in March 2022. A primary goal of AAPOS is to improve advocacy at the state level by hiring a lobbyist with state experience. The role of the lobbyist is to advocate with state legislatures for Medicaid coverage for MM because the out-of-pocket costs of MM for many families is a hindrance to treatment.

Myopia and its risk need to be identified early and treated early.

Vision screenings by qualified individuals is a great way to identify children who need referrals to an eye care provider for a comprehensive eye exam. In countries that do not provide vision screenings, public health campaigns on myopia are a cost-effective strategy to promote MM and the risks of myopia. Ultimately, the goal is globally to identify more children with myopia early to increase the opportunity to treat their myopia early. Indeed, the greatest hurdle to achieving the goals of the AAPOS is that advocacy must achieve success in 50 different states because legislation is at the state, not the federal level. Encouraging coordination between industry partners, the AAPOS and the AAO may be helpful to pass legislation. These three entities can gather their resources, such as their state contacts and lobbyists, to achieve state-by-state level Medicaid coverage for MM treatments.

“In general, in order to manage myopia holistically, we have to offer a wide range of MM treatment modalities in our practices,” Foo said. “Each patient is different in terms of their needs and lifestyle, as well as myopia progression. If one monotherapy treatment does not work, then we should move on to the next available MM treatment modality or even consider combination therapy to give the patient their best shot at minimizing their final myopia. Given that some parents are averse to pharmacologic treatments, we need to recommend optical MM treatment modalities. Ophthalmologists in Singapore, like in the United States, also need to advocate for better coverage of MM spectacles and contact lenses. Unfortunately, at this time Singapore’s public health system does not pay towards optical interventions in MM, which can limit access for patients.”

“In the United Kingdom, the Royal College of Ophthalmologists is one of the relevant stakeholders to guide and to offer support to our profession,” Jawaid said. “They are paramount in validating clinical management through publicly available accreditations, strategies and guidelines. The Royal College of Ophthalmologists needs to also support the optometry societies to further validate MM, a field that is vastly changing.”

“In Spain, it is paramount that ophthalmologists begin to support optometrists by publicly advocating for MM and by recommending MM to patients within their clinics,” Ceña said.

They also must understand that MM is treating a condition in the present to lessen the chance of poor visual and eye health outcomes in the future.

In addition to support with legislation, industry may also assist the national and international pediatric ophthalmology societies in promoting MM through several different avenues. Industry has the capability to produce multiple resources that can educate the public, such as handouts, pamphlets, short video clips, digital education and social media. Given that the business side of MM can be overwhelming, industry may help ease the practice transition into MM by providing information on best clinical and business approaches for ECPs through digital education and practice marketing toolkits. Most importantly, success and advancements in MM require a strong national and international network among ophthalmologists, optometrists, and other health care professionals together with industry.

Educational Resources

Scientific and clinical websites and publications play an important role in educating ophthalmologists, both general and pediatric. Through a generous donation by the Knights Templar Eye Foundation, the Pediatric Ophthalmology Education Center was created by partnering with the AAO Ophthalmic News and Education (ONE) Network. This educational center has a substantial amount of information containing clinical research on MM. Practical information is found in ophthalmology trade publications, which include clinical and business advice via comments from leading experts. The journal and workshops of the AAPOS and the AAO, as well as continuing education at meetings and webinars, are also a good source of information on MM for pediatric and general ophthalmologists.

“In the United Kingdom, many ophthalmologists still lack education on MM,” Jawaid said. “Continuing Professional Development programs at the Annual Congress of the Royal College of Ophthalmologists and by the British & Irish Paediatric Ophthalmology and Strabismus Association are good platforms to offer education and workshops on MM.” Small group settings, such as workshops and clinic sessions, are also valuable educational opportunities that encourage discussions and debates, which often influence the practice mindset of ophthalmologists, Ceña added. “In general, pediatric ophthalmologists need to better inform general ophthalmologists on MM and on the concept of myopia as a disease to at least prompt a referral for MM,” Ceña said.

In addition, CooperVision provides ECPs with representatives who offer valuable education and advice. It also lists certified providers of MiSight® 1 day contact lenses for age-appropriate patients on its website (<https://coopervision.com/misight-ecp-finder>) and for ECPs looking for MM providers. CooperVision Specialty EyeCare also lists certified Paragon CRT providers on its website ([https:// www.paragonvision.com](https://www.paragonvision.com)).

“In my opinion, a spectacle lens approval for myopia control is a good way for ophthalmologists who have resisted MM to enter the realm because we all prescribe spectacle lenses,” Laura B. Enyedi, MD, said. “I think that once ophthalmologists are prescribing spectacle lenses for MM, then the transition to prescribing MiSight® 1 day contact lenses for MM will be easier.”

Summary

Treating myopia and its progression as early and as close to its onset is critical during childhood to lower the risk for myopia pathology that may lead to permanent visual impairment. The alarming increase in the global prevalence of myopia underlines the

importance of eye care professionals leading an international effort to educate and advocate on myopia and its treatments. The safety and efficacy of today's evidence-based optical treatments for children with myopia brings confidence to practitioners and families alike that these treatments may successfully slow progression.

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*Indications for use: MiSight® 1 day (omafilcon A) soft (hydrophilic) contact lenses for daily wear are indicated for the correction of myopic ametropia and for slowing the progression of myopia in children with non-diseased eyes, who at the initiation of treatment are 8-12 years of age and have a refraction of -0.75 to -4.00 diopters (spherical equivalent) with ≤ 0.75 diopters of astigmatism in U.S. markets. The lens is to be discarded after each removal.

+ Availability and indications for use varies by country. CooperVision does not endorse off label use of myopia management interventions. The views and opinions of those contributing to this article do not necessarily reflect the entities they represent.

CooperVision provided support for this roundtable, in addition to support for the participating ophthalmologists. The article was written by Mindy Nash.

*Preliminary international study data shows that, on average, for children that discontinued treatment at age 14-19 following 3 or 6 years of MiSight® 1 day wear, the eye growth reverted to age-expected average myopic progression rates.

Disclaimer: The stability of the myopia reduction effect 1-year post-treatment is being further evaluated in a post-approval study in the U.S. as a condition of FDA approval for MiSight 1 day.

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