Transcript Details
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Patient-Centered Care in Dry Eye Disease

Announcer:
This is *On the Frontlines of Dry Eye Disease* on ReachMD. Here's your host, Dr. Steve Jackson.

Dr. Jackson:
Welcome to *On the Frontlines of Dry Eye Disease* on ReachMD. I'm Dr. Steve Jackson, and joining me to discuss how we can improve patient education, adherence, and quality of life in dry eye disease is Dr. Kaleb Abbott. He's an Assistant Professor of Ophthalmology at the University of Colorado.

Dr. Abbott, welcome to the program.

Dr. Abbott:
Thanks for having me on, Steve.

Dr. Jackson:
To get us started, Dr. Abbott, when you first diagnose a patient with dry eye disease, how do you help them better understand the condition and set expectations about their care?

Dr. Abbott:
I think the first step when you're evaluating a dry eye patient is, is this actually dry eye? Dry eye is really supposed to be the combination of signs and symptoms. So you're supposed to have a patient who is experiencing symptoms of discomfort, and then we are supposed to see objective signs of dry eye, and then together, that gives you a diagnosis of dry eye. But all too much, we see that patients maybe have symptoms but no observable signs, or the opposite, where they have observable signs, but they're not actually having symptoms. So oftentimes, I think it's a lot more complicated than just dry eye or no dry eye.

There's a lot of questions of pain perception at play. There's questions of nerve hyperexcitability, which can be indicative of a neuropathic element to their pain. There can also be reduced symptoms and a lot of objective signs that can also be indicative of reduced nerve function. So when it comes to setting expectations, I think it really centers around figuring out where each individual patient lies on this spectrum of signs versus symptoms.

Dr. Jackson:
And beyond the symptoms that patients describe in the clinic, as well as those signs that you see, how can dry eye disease affect their day-to-day quality of life?

Dr. Abbott:
I think that this is really the most underappreciated aspect of dry eye. So you're really not supposed to think about your eyes. During the day, you don't think about your hands, you don't think about your feet, you shouldn't be thinking about your head. But when it comes to dry eye, these patients are just thinking about their eyes really all day long because their eyes are constantly bothering them.

And the terminology of "dry eye" is really a disservice to patients. We recently just published a paper looking at sign and symptom discordance. We were asking optometrists and ophthalmologists, "What are the most important symptoms to you when you're diagnosing someone with dry eye?" And dryness was actually the fifth most important symptom, meaning there are four symptoms that are actually more important than dryness. So the terminology is just really bad.

And because we call this dry eye when it's really just eye pain, it really undervalues the quality-of-life implications. So I think one thing that is worth mentioning here is that when it comes to most pain syndromes, we're talking about affecting senses. We're talking about

affecting feeling something—the sense of feeling. When it comes to dry eye, we're actually not just talking about the sense of feeling; we're also talking about their vision too, which a lot of people rank as their most important sense. So you're talking about patients who are having symptoms of discomfort and who are in pain, and then their vision is also impacted.

So if they have central corneal staining, or what we call corneal epitheliopathy, this can cause constant blurred vision for these patients. So all day long, these patients experience blurred vision. If their tear film is not intact and not healthy and they don't have all the different components of the tear film mixing together and staying there an appropriate amount of time and not evaporating, then they get fluctuating vision. So in between every blink, their tears start to evaporate, and then it causes fluctuating vision. Then, on top of that, sometimes you get irregularity of the cornea or irregularity of the tear film, and this induces higher-order aberrations. So it can really impact patients' vision with constant blurred vision, fluctuating vision, and then just not clear images.

So the top things that patients will actually rank when saying, “This is affecting my vision every day,” dry eye, that is, are things like driving at night, seeing road signs, reading, navigating stairs, watching TV, cooking, and then lastly, recognizing friends, which is so sad. Patients will actually say, right, "This makes it difficult for me to recognize the people around me."

So if you look at quality-of-life assessments, this is how we really compare different conditions to each other to figure out how it actually impacts quality of life. If you take a patient who has moderate-to-severe dry eye, it impacts their quality of life similarly to someone who has moderate or severe angina, so someone that's going around having this intermittent and bothersome heart pain and chest pain all day. And then it also can impact patients similar to having a disabling hip fracture. So these are really serious things that impact quality of life, and dry eye, when it's severe, can impact it on a similar scale to that, but we don't really think about that.

Another component of dry eye is the financial component. So in 2011, it was estimated that severe dry eye is costing patients about $1,300 per year. That was back in 2011. So I would estimate today, a severe dry eye patient's probably spending $3,000 to $4,000 a year trying to manage their eye discomfort and the visual aspects of their dry eye. In 2011, severe dry eye also cost $18,000 annually in terms of lost productivity, and again, it would be more than that today. Just yesterday, I had a patient who had a LASIK procedure, and after the LASIK, she was having such terrible eye pain that she actually went on disability for six months. And then once she went back to work, she went from being full-time to now part-time just due to the discomfort of her eyes and trouble with her vision. So this can be quite serious. It's also estimated that dry eye patients take about two to five days off from work annually due to their dry eye symptoms.

And then lastly, I would say that out of all the different eye conditions that are out there, dry eye is strongly associated with depression, anxiety, and poor sleep more than any other eye condition.

Dr. Jackson:
So how do you bring those quality-of-life concerns into a patient's care plan?

Dr. Abbott:
I think the first thing is you need to bring compassion into the exam room. You have to understand that these patients are suffering, they're struggling, and we need to be compassionate.

The second thing we need to do is we need to listen to them. Sometimes, these patients are very difficult to treat, and we're running out of options, and the best thing that we can do in our exam time is just to listen to them and to lend an ear. And it can be really empathetic for that patient just to sit there and to be heard. So we need to empathize with them.

We also need to believe them. All too often, sometimes these patients are disregarded and they're told, "No, I don't believe you're having all the symptoms that you're describing that you're having." But there's tons of studies out there, showing us that just because we don't see objective signs of damage to the eye doesn't mean these patients don't have pain.

And we can actually do special tests like zooming in on the corneal nerve 600 times, and you can see signs of eye pain that you otherwise would not be able to see in a normal eye examination. So we need to believe that their eye discomfort exists. We need to not disregard them.

But then most importantly, you have to give them hope. You do not want to tell the patients, "We're out of options." You don't want to make the patients feel like they're going to be living with this for the rest of their lives. You need to say, "We have options for you. We will keep trying." And you need to give them hope at the end of each exam. I think that's probably the most important thing.

Dr. Jackson:
For those just tuning in, you're listening to *On the Frontlines of Dry Eye Disease* on ReachMD. I'm Dr. Steve Jackson, and I'm speaking with Dr. Kaleb Abbott about how we can better support patients with dry eye disease.

Dr. Abbott, what challenges can make it difficult for patients to follow their management plan?

Dr. Abbott:
To be honest, I'm actually sometimes delighted when patients are not following the plan, because if they're not following the plan, that usually means that we're winning. That means that their eyes are feeling better. They're not thinking about their eyes. They're forgetting to use their drops.

Sometimes, when we think of poor adherence, we think, "How can we get these patients to adhere better? How can we make them more compliant?" But when it comes to a disease like dry eye, we're talking about a very symptom-forward disease where symptoms really are king. So if they're forgetting to use their drops, sometimes, that's actually indicative that your plan is working quite well, or maybe it means we can actually finally cut back on all the different treatments that we're doing, and we can try to simplify our treatment plan for that patient.

The only exception to that is if we're worried about progression or if we're worried about permanent damage to the eyes, to the cornea, or to the meibomian glands. That's when you have to put on the doctor cap, and you have to make sure that the eyes are safe and that it's not going to lead to anything that could cause a permanent problem for that patient.

But again, symptoms are king, so adherence is oftentimes an indicator of the patient's current state of their symptom severity.

Dr. Jackson:
What strategies have you found most effective in helping these patients to stay engaged with their care?

Dr. Abbott:
What I like to do is try to give patients some control. It's important to be the doctor, but as a doctor, you can also give patients options. You can say, "This is what we think is driving your dry eye signs and your dry eye symptoms based off all of our objective testing and the entire clinical picture." And you can say, "We can be prescribe X, Y, or Z for you. We could do this cash pay procedure. We could do this." And you give patients options. And when you give them control, they will let you know what makes the most sense for them. Sometimes, we're talking about a drop that you're using four times a day versus a different drop that's twice a day, and they say, "Well, I've got a busy life. I don't think I can remember to put in a drop four times a day. Twice a day works better for me." Or sometimes you say, "I've got this cash pay procedure that actually is a great option for you," and they say, "I've got financial constraints. That doesn't make as much sense in my situation."

So really, I think it's important to give the patients control, give them different options, and explain to them the pros and cons of all the different routes that you can go down. And patients, in the end, know best. They know what is most reasonable for them. They know what is most doable when it comes to their life.

Dr. Jackson:
That's a great way to round out our discussion. I want to thank my guest, Dr. Kaleb Abbott, for joining me to share his perspective on improving patient education, adherence, and quality of life in dry eye disease. Dr. Abbott, it was great having you on the program.

Dr. Abbott:
Thank you so much for having me here, Steve. I really appreciate it.

Announcer:
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