Many contact lens practitioners are interested in adding “dry eye exam” elements into clinical practice, but the logistics can be a challenge. Can a five-minute exam really happen? Consider the following suggestions:

**Tailor a form to the specific needs of an ocular surface exam**

Differentiating your ocular surface assessment exam form from your routine examination (or contact lens fitting assessment) form or electronic medical records template will serve as a reminder that this exam is handled differently from routine eye care. The [Ocular Surface Society of Optometry](http://www.ossopt.com/) provides access to several dry eye examination forms for its members.

**Start by assessing symptoms**

Critical to the ocular surface exam is the assessment of symptoms, particularly in differentiating dry eye from anterior blepharitis:

|  |  |
| --- | --- |
| ***Dry eye*** | ***Blepharitis*** |
| End-of-day dryness, fluctuating vision | Morning symptoms, burning, dryness, red eyes or eyelids |

If you prefer to conduct your own interview, consider asking the following key questions:

- Do you use any over-the-counter eye products with or without contact lenses (If yes, do they work)?  
- What is your worst or most noticeable symptom and when is it worst?  
- Do you have burning or eye redness in the morning?  
- Do you have symptoms when not wearing lenses?

Itching can occur with most anterior segment conditions, so asking about the severity or time course of itch may help rule out ocular allergies. Of course, symptoms of dry eye, blepharitis and allergy often overlap, and this may be more apparent in seasons with high pollen levels, more arid conditions, and with more time spent outdoors or in forced-air environments.

**Conduct an ocular surface exam**

The ocular surface exam should take no more than five minutes, especially if you include a checkbox on the examination form. Consider the following checklist:

***Lid and lash assessment***

- Assess the lashes for debris, flakes, crusting and collarettes  
- Look for any lid abnormalities (notching)  
- Assess lid margin redness

***Meibomian gland assessment***

- Check for redness around the meibomian glands (posterior lid margin redness)  
- Evaluate the meibomian glands for blockage and expression of meibum, using constant pressure with a finger or Q-tip for 15 seconds, just under the base of the eyelashes  
- Assess the quality of the meibum; is it clear, slightly cloudy/ granular, cloudy or pasty?

***Tear film assessment***

- Assess the quality of the tear film in the tear prism  
- Check for reduced tear break-up time  
- Assess tear production – particularly the first time you see a patient with ocular dryness/ irritation  
- Conduct a Schirmer test (poor = ≤ 5 mm/5 minutes) OR a phenol red thread test (poor ≤ 9 mm/15 seconds)

***Assessment of cornea and conjunctiva***

- Assess redness of the palpebral and bulbar conjunctiva  
- Look for a papillary or follicular reaction of the conjunctiva  
- Conduct white-light and fluorescein staining assessments of the cornea  
- Conduct green staining assessments of the conjunctiva

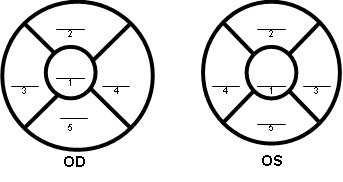
[](http://www.contactlensupdate.com/wp-content/uploads/2012/01/Nichols1.jpg)

Figure 1. Five corneal staining regions

The following three things need to be considered when selecting a management strategy for a patient:

***Patient motivation/ compliance***

Motivation is a significant factor in dry eye and lid disease management. Currently, artificial tears and cyclosporine A (Restasis) are mainstay therapies for dry eye, while the combination of lid hygiene and warm compress application (with or without topical antibiotics) is currently considered to be within the standard of care for blepharitis. While no good data exist on patient compliance with most therapeutic modalities, especially warm compresses, anecdotally nine of ten clinicians would say that a patient rarely maintains non-Rx therapy for longer than two weeks (artificial tears may be an exception). It may be unrealistic to think of lid hygiene and warm compress therapy as a solitary therapy for blepharitis, especially when compliance is a significant issue with a chronic disease.

***Chronicity of the presenting signs and symptoms***

The severity of a disease is often linked clinically to its chronicity, though they are not the same thing. Most would agree that the longer someone has a disease, the worse the disease can be. To date, there have been no long-term natural history studies of dry eye or blepharitis, so we do not know what influences the severity or chronicity, as well as the long-term response to therapy.

***The mechanism of therapeutic action***

Long-term management as well as possible prevention of progression should be considered when selecting a therapy. Lastly, the mechanism of therapeutic action should be plausible, safe, and effective.

**A last word**

Adding a “dry eye clinic” to a contact lens practice can increase the bottom line, both directly and indirectly (via referrals), but the rollout needs to be well planned and orchestrated. Incorporating staff in-services about the therapeutic plans you are adopting will help your staff deliver and reinforce your message to your patients, helping you to optimize your ocular surface disease practice.