

**BAUSCH + LOMB**

# Boston® Update

## Overcoming Contact Lens Compliance Challenges

An interview with Pauline Cho, PhD, FAAP, FBCLA, associate professor of the School of Optometry at The Hong Kong Polytechnic University.

Dr. Pauline Cho has published extensively in optometric and contact lens journals. Her research interests include compliance in contact lens wear and care, as well as microbial contamination of lenses and lens accessories. *Boston Update* recently asked Dr. Cho to share her insights regarding these important topics.



Dr. Pauline Cho

### What are the toughest compliance-related challenges facing contact lens practitioners?

I believe the top two challenges are convincing patients to return to us for aftercare consultations and convincing them to properly care for their contact lens accessories in addition to their lenses.

### Are these issues related more to a patient's age, personality or lifestyle, or to the type of lenses the patient wears?

I believe these issues stem from a patient's level of awareness. It is difficult to change behaviors if patients do not think they are doing anything wrong or if they do not understand the risks involved in what they think are safe practices.

Age, personality and lifestyle play important roles, too. For example, patients may claim they are too busy to properly care for their lenses, or they may just be lazy. Lens type is probably not as important. I have found that children are likely to nap while wearing their lenses when traveling to and from school and even during classes.

### What are the consequences of noncompliance? Please describe some of the relevant findings from your studies. What actions do you recommend to prevent these complications?

The worst possible consequence, of course, is loss of vision, or blindness due to infection, which can result from contamination due to inadequate care. Our studies have shown high levels of contamination of lens accessories.<sup>1</sup>

To avoid these problems, practitioners must review and reeducate patients as frequently as possible. This is one of the important functions of regular aftercare consultations. For children undergoing orthokeratology, we recommend aftercare consultations every

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### Events Calendar

#### May

8-11	French Society of Ophthalmology (SFO),* Paris, France
13-15	EFCLIN,** Riga, Latvia
27-30	BCLA,* Birmingham, UK

#### June

1-2	Congress of Ophthalmology, St. Petersburg, Russia
3-6	AAD World Ophthalmology Congress (WVAO), Berlin, Germany
16-20	American Optometric Association,** Kissimmee, Fla., USA

#### July

10-11	Japan Contact Lens Society,* Tokyo, Japan
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\* Bausch + Lomb Boston attendance

\*\* Bausch + Lomb Boston exhibit

3 months, and for older teens, at least every 6 months. Regular reminders do work, although the effect does not last. Other strategies we use with children who are undergoing ortho-k include:

- **Using automatic recall for aftercare consultations.** We know we cannot leave this up to the parents.
- **Obtaining payment in advance for aftercare consultations.** This usually ensures that parents will bring in their kids.
- **Avoiding unnecessary accessories.** In ortho-k, we teach the kids to apply and remove their lenses with their fingers instead of suction holders. The latter are convenient, but I believe that convenience comes at the expense of safety. Lens binding is more frequent in ortho-k, so trying to remove a bound lens from the eye with a suction device is dangerous. Also, the rate of contamination of this item is high, and compliance with cleaning and disinfecting it is poor.
- **Providing a leaflet with clear step-by-step instructions from hand-washing to storing the lens case.** This covers all aspects of lens and accessory care, such as removing the caps of solution bottles and the lens case before washing hands.
- **Photodocumenting.** A picture is worth a thousand words! This is really very true when dealing with adverse effects. Noncompliant patients do not need much convincing after they have seen photos of their eyes or their lenses.



One of the top two challenges facing practitioners is convincing patients to care for their lens accessories.

### What cleaning regimen do you prefer for GP lenses?

I prefer the use of separate solutions. A multipurpose solution for disinfection, saline for rinsing before application, and a separate cleaner. Because GP lenses are not replaced as frequently as soft lenses, it is important that they are as clean as possible, so I also have patients do a protein removal treatment weekly. Patients will always find ways to be noncompliant, whatever we give them, so I prefer to get them started with a complete set of procedures.

### Do you recommend the use of liquid enzyme cleaners for GP lens wearers?

Yes, I do, because deposits left on the lens surface are likely to attract more deposits. Over time, they are more difficult to remove and will lead to adverse events.

### How often do you recommend replacement of contact lens storage cases?

Patients should replace their lens cases every time they replace their bottle of multipurpose solution, approximately every 4 to 6 weeks.

### Do you use special training methods when teaching young GP lens wearers how to apply, remove and care for their lenses? Do you also train their parents?

We teach all children to use finger-lid manipulation or the blink method to remove GP lenses. For young kids who are initially too nervous to touch their eyes, we use the “eye drop” method to teach them how to apply their lenses.<sup>2</sup>

We do not dispense contact lenses to kids unless they learn how to apply and remove them. We cannot allow them to depend on their parents. In ortho-k, however, we do teach the parents lens application and removal, in case the children have problems. The kids wear their ortho-k lenses only at home, so we believe it is acceptable for parents to apply and remove the lenses for them. From our experience, however, kids usually prefer to apply and remove their lenses themselves.

As for lens care, most of the younger children do not want to clean their lenses, especially in ortho-k, mainly because they fear breaking the expensive lenses. So the parents are usually in charge of caring for the lenses. ▶

1. Cho P, Boost M, Cheng R. Non-compliance and microbial contamination in orthokeratology. *Optom Vis Sci.* 2009;88:1227-1234.

2. Cho P, Cheung SW. Fitting kids with contact lenses. *Contact Lens Spectrum.* 2009. 24;8:34-39.

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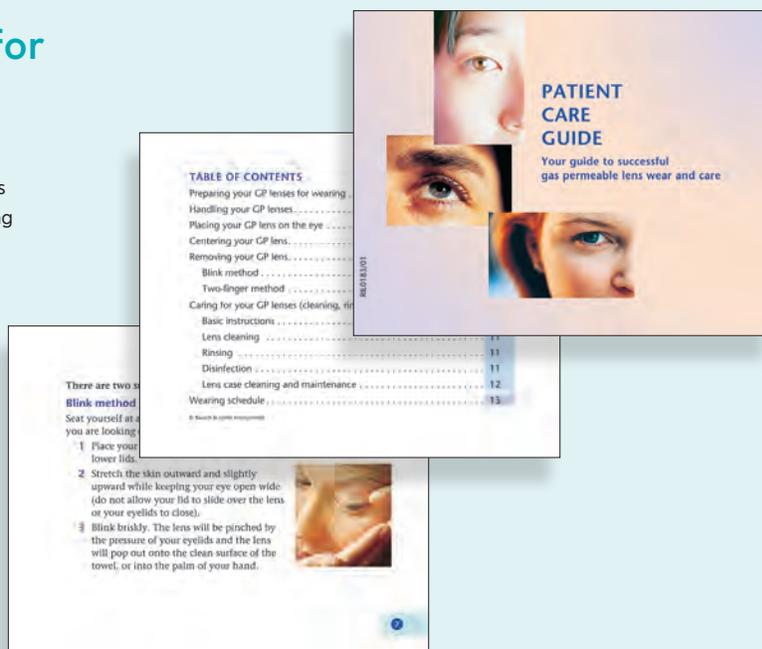
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# Care and Handling Tips for Contact Lens Wearers

The single best way for patients to avoid eye infections is to follow proper lens care guidelines as prescribed by their eye care professional, according to the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgery, the Contact Lens Association of Ophthalmologists and the Cornea Society. Their joint publication, "Taking Care of Your Contact Lenses," is shown below in a format suitable for photocopying for your practice..

For the full text of the joint statement, go to [www.corneasociety.org/pdf/cl-070708.pdf](http://www.corneasociety.org/pdf/cl-070708.pdf).

To order copies of Bausch + Lomb's "Patient Care Guide" for your practice, ask your authorized Boston lab for publication #RIL0183/01.



## Taking Care of Your Contact Lenses

- Before handling contact lenses, wash your hands with soap and water, then rinse and dry them with a lint-free towel.
- Minimize contact with water; remove lenses before swimming or going in a hot tub.
- Do not put your lenses in your mouth to wet them. Saliva is not a sterile solution.
- Do not use saline solution and rewetting drops to disinfect lenses. Neither is an effective or approved disinfectant.
- Wear and replace contact lenses according to the schedule prescribed by your eye care professional.
- Follow the specific contact lens cleaning and storage guidelines from your eye care professional and the solution manufacturer.
- During cleaning, rub your contact lenses, then rinse the lenses with solution before soaking them. This "rub and rinse" method is considered by some experts to be a superior method of cleaning, even if the solution you are using is a "no-rub" variety.
- Rinse the contact lens case with fresh solution – not water. Then leave the empty case open to air dry.
- Keep the contact lens case clean and replace it regularly, at least every 3 months. Lens cases can be a source of contamination and infection. Do not use cracked or damaged lens cases.
- Handle your contact lens solution with care:
  - › Do not re-use old solution or "top off" the solution in your lens case.
  - › Do not transfer contact lens solution into smaller travel-size containers. This can affect the sterility of the solution, which can lead to an eye infection.
  - › Do not allow the tip of the solution bottle to come in contact with any surface, and keep the bottle tightly closed when not in use.
- If you store your lenses in the case for an extended period, consult the instructions for your lenses or the contact lens solution to determine if re-disinfecting the lenses is appropriate before you wear them. In no case should you wear your lenses after storage for 30 or more days without re-disinfecting.
- Some experts recommend that if you use contact lenses sporadically, consider using single-use daily disposable lenses.



For back issues of Boston Update, and to join our mailing list, visit us at: [www.bausch.com/en\\_US/ecp/visioncare/general/boston\\_archive.aspx](http://www.bausch.com/en_US/ecp/visioncare/general/boston_archive.aspx)



# Prescribing for Pediatric Aphakia

This unique multifocal lens design is available to all.

By John Mountford, Dip App Sc, FCLSA, FAAO FBCLA



In 1993, my friend and colleague, Dr. Tony Phillips of Adelaide, South Australia, told me about a pediatric ophthalmologist who was leaving Adelaide to set up practice in Brisbane. Dr. Phillips asked if I would be interested in fitting aphakic babies with contact lenses following cataract surgery. I found this an interesting and challenging proposition, and it has led to the development of a specialized lens design.

## From hydrogel to GP

When we began fitting aphakic babies, we used high water content soft contact lenses, but after a few months, it became obvious that daily wear soft lenses were not the answer. The trauma to the child of lens application and removal was a major factor, and parents must be incredibly motivated to put themselves and their babies through that daily ritual. Another factor was the poor reproducibility of the lenses. A +30.00D soft lens is actually +90.00D in the dry state, and it was not uncommon for the lens powers to be significantly inaccurate.

The beauty of GP lens materials and CNC lathes is that the accuracy and reproducibility are excellent. The aim was to design a large-diameter lens (11.50mm) that would not be easily lost, and to maximize the optics to achieve a multifocal effect.

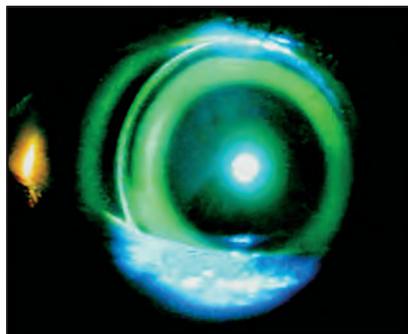


Figure 1: Fluorescein shows ideal fit of pediatric aphakic lens.

was focused for distance but also allowed for clear near vision made the most sense.

Dr. Michael Collins at Queensland University of Technology was a big help in this regard. He calculated that a +25.00D lens could have up to 12.00D of positive spherical aberration at a front optic zone diameter of 5.00mm. Combined with a back-surface asphere and a front-surface sphere, this gave a calculated add of 2.50D and a theoretical depth of focus of 14.00D.

The resulting design is as follows:

- 11.50mm total diameter, which can be altered depending on the HVID
- 6.00mm central back optic zone; and 0.98 eccentricity

- Aspheric peripheral curve with the same radius as the base curve, but eccentricity of 0.70
- 5.00mm spherical front optic; 0.12mm junction thickness
- The trial lens set consists of lenses of BOZR 6.80mm to 7.50mm and a power of +25.00D.

## Typical fitting

Typically, we fit a baby 1 week after cataract extraction. If K readings were taken during the procedure, we fit the initial trial lens 2.00D steeper than flat K. If K readings were not taken, we use an initial trial lens of 7.00mm BOZR.

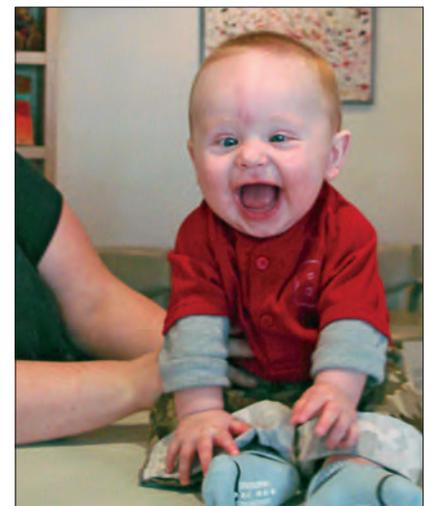
Prior to lens application, we instill a drop of 0.4% benoxinate with fluorescein. The lens is applied with a suction cup, and the fluorescein is pattern assessed, using either a hand-held slit lamp with Wratten 12 filter or a Bluminator with a Wratten filter taped onto the back surface. An ideal fit will show mild central pooling, a wide peripheral alignment zone, good centration and good edge lift (Figure 1). If the lens is too steep, there will be excessive central pooling and a tight edge. If the lens is too flat, movement will be excessive and the edge lift too wide.

The power of the lens is determined by retinoscopy but at a working distance of 33cm, not the usual 66cm. Because there is no accommodation, halving the working distance quadruples the brightness and clarity of the ret reflex (the inverse square law), making determination of the final prescription more accurate. The final prescription lens is then ordered from the laboratory and delivered within 2 days.

## Dispensing and follow-up

We teach the parents to apply and remove lenses with suction cups, a normal suction cup for application and a DMV 45-degree suction cup for removal. This simplifies and shortens the process, which is far less traumatic for the child. Lenses are cleaned and stored with Boston Advance daily cleaner and conditioning solution. The wearing schedule is 6 nights on, 1 night off until the child is old enough to learn how to apply and remove his own lenses, usually between 4 and 5 years of age. The lenses are then worn on a daily wear basis.

The parameters of the lens are changed on a regular basis as the child grows: the BOZR is flattened and the power decreased as needed. Regular review is essential. Parents become quite expert at determining when the lens requires flattening, as it becomes relatively steep and tight and difficult to remove.



## Long-term success

Over the last 16 years, I have fitted more than 200 children with GP lenses, mainly for aphakia, but also for anisometropia, high astigmatism, facial abnormalities that prevent spectacle wear and other conditions. The success rate with Boston XO<sup>®</sup> and now Boston XO<sub>2</sub><sup>®</sup> is very high, with excellent visual outcomes and a total dropout rate of approximately 10%.

The design of the pediatric multifocal lens I have described is in the public domain and can be made by any laboratory with the proper lathes. ▶

*Dr. Mountford practices in Brisbane, Australia. He has designed lenses for orthokeratology, keratoconus and pediatric aphakia, as well as a new miniscleral lens in conjunction with Don Noack. He has numerous academic and professional awards and lectures nationally and internationally.*

## Childhood in Focus

In clinic recently, I saw a 10-year-old bilateral aphakic boy, who was fitted with the pediatric multifocal lens at 6 weeks of age. He has successfully worn his lenses for the entire time and has visual acuities of 20/20 OD, 20/20 OS and can read N8 at near without reading glasses and N5 with reading glasses.

# Relief for Severe Burn Victims

Placing a contact lens on an eye can be life-changing for some patients. Never has this simple act produced more dramatic results than at a U.S. Army burn center.

*By Virginia Pickles, Contributing Editor*

The conflicts in Iraq and Afghanistan have taken an immeasurable toll on countless lives. On any given day, the news media generate startling images, sound bites, data and statistics, which sometimes obscure the long-term impact on the men, women and children who are affected by war.

Perry Rosenthal, MD, founding president of the Boston Foundation for Sight (BFS) in Needham, Mass., learned first-hand about some of the devastating injuries U.S. soldiers have sustained when he received a call from an Army ophthalmologist, working at a burn center. That call set in motion a series of life-changing events for injured soldiers there.

## Failed treatments

One particularly challenging case prompted the call to Dr. Rosenthal. A soldier had sustained severe facial burns in the periocular region and the scalp. Burn specialists had attempted three grafts – face, head and eyelids – but they had failed, and the physicians would have to wait 3 months before they could try again. The soldier's globe was completely exposed, and treatments to preserve his cornea were not working.

The Army ophthalmologist first contacted Stephen C. Pflugfelder, MD, in Houston, who suggested applying a Boston Scleral Lens (now called the Boston Ocular Surface Prosthesis or BOS-P). Upon that recommendation, the Army contacted Dr. Rosenthal. Shortly thereafter, armed with 18 diagnostic lenses, Dr. Rosenthal was on a plane headed for the burn center. What he found there was unlike anything he'd ever seen.

## Devastating injuries

"Some of these soldiers – the Army calls them Warfighters – had been incinerated by roadside bombs and had suffered third-degree burns over their faces," Dr. Rosenthal recalls. "Their eyelids were literally burned off. Despite round-the-clock treatment with ointments, lubricants

and moisture goggles, their corneas would ulcerate and perforate. They would need emergency transplants, and then there was a chance the transplants would become ulcerated and perforated. Nothing they tried was working.

"One of the first soldiers I met had undergone emergency corneal transplantation in one eye early that morning, and the cornea of his other eye was becoming ulcerated. I fitted the other eye with the BOS-P and in 24 hours, the ulcer had almost healed." (See "The BOS-P at a Glance" for more on this lens.)

Dr. Rosenthal fitted several other patients in the intensive care burn unit, the burn ward and the outpatient clinic. His successes were so dramatic that the Army sent an optometrist to the BFS clinic on a 3-month fellowship to master the DTF™ CAD/CAM design/manufacturing software program for custom-designing the BOS-P.

## Transformative therapy

For the small number of severely injured soldiers with periocular burns, the BOS-P lens has been a major factor in achieving better outcomes, Dr. Rosenthal reports. "Patients have fewer infections, and the lens has affected how well they see after they leave the burn ward," he says. The improved outcomes are not only physical, but also emotional and psychological.

"It's difficult to describe what you see in the burn ward," Dr. Rosenthal says. "A soldier may be one big bandage, with arms and legs splayed out, and only his eyes showing. Before the



Perry Rosenthal, MD, fitted severely burned soldiers with BOS-P lenses to help protect their corneas during the healing process.

Army started using the BOS-P lens, in the absence of the eyelid, the only alternative was to close the orbit to protect the eye."

Yet the time period when a patient has no protection from the eyelid is usually when he is sickest. "The patient can't move. He has multiple lines in every extremity, and if the doctors must close the orbit, the patient can't see to interact with his family and the medical team," Dr. Rosenthal explains. "The BOS-P lens allows the soldier and his family to work through his treatment. It's a therapeutic device that also enables him to cope psychologically. Words cannot describe the positive impact when a patient is able to see everything that is happening."

One patient had significant lid injuries in addition to a corneal infection, which required hourly drops. The patient was unable to participate in physical therapy because of the drug regimen. After being fitted with the BOS-P lens, the patient was able to do his PT while still receiving treatment for corneal ulcers. A resident applied the lens in the morning and returned later to remove it. After his physical therapy, the patient often asked the resident to return later, so he could wear the lens a little longer.

## Lives reclaimed

After using the BOS-P lens for inpatients, the Army sent some patients to the BFS clinic for fittings. Among those patients was a bilateral amputee who had undergone lid grafting, but the lid was not functional. Although he had some protection, he still needed drops throughout

## The BOS-P at a Glance

The Boston Ocular Surface Prosthesis (BOS-P), formerly called the Boston Scleral Lens, is a fluid-ventilated gas-permeable contact lens that rests entirely on the sclera, creating a fluid-filled space over the diseased cornea.

To avoid lens suction, the BOS-P bearing surface (haptic) is manipulated with splines to avoid excessive compression of the underlying sclera. This facilitates the aspiration of tears into the precorneal tear compartment. This design technology aborts the development of negative hydrostatic pressure while avoiding the transit of air bubbles.

The BOS-P is fabricated from Boston Equalens® II material (oproficon A; Dk 85) by state-of-the-art Nanoform-250 Ultra lathes that were custom designed for the Foundation's needs. Both are gifts from Bausch + Lomb, Rochester, NY.

the day and ointment at night. For his spouse, this was full-time duty. After being fitted with the BOS-P lens, both the patient and his spouse regained their independence. The patient declared, "I got my life back." ▶

## I-site Marks 1-Year Anniversary

International e-mail newsletter focuses on all things GP.

I-site is an independent educational newsletter that provides objective and timely information on GP-related topics based on scientific research, case reports and other publications worldwide. Edited by Eef van der Worp, BOptom, PhD, FAAO, FIAACLE, FBCLA, I-site is distributed monthly via e-mail to more than 3,500 subscribers. The Boston Group of Bausch + Lomb is pleased to be a commercial supporter of I-site and congratulates Dr. van der Worp on reaching this milestone.

For more information about I-site, to view the newsletter archive or to sign up for a free subscription, go to <http://www.netherlens.com/>

The collage displays several issues of the I-site newsletter. Key articles visible include:

- Wooden Shoes:** Discusses contact lens wear in the Netherlands and the use of wooden shoes.
- Corneal Biomechanics: Hysterical about Hysteresis?** Explores the biomechanical properties of the cornea and sclera.
- Myth or Megatrend?:** Discusses the potential for slow-down myopia progression.
- Tear Mixing: Music to my tears!** Focuses on efficient tear mixing and removal of cellular debris.

A QR code is positioned at the bottom left of the newsletter collage.



## Spotlight on David Bland

For this issue's Spotlight, we spoke with David Bland, Director, Global Boston GP Business.

### **Please tell us about your background and your experiences before joining Bausch + Lomb?**

I was born in Richmond, Va., and lived in Tennessee, Mississippi and Kentucky before my family settled in Plano, Texas, a suburb of Dallas,

in 1972. I have lived in the Dallas-Fort Worth area ever since. I attended Stephen F. Austin University in Nacogdoches, Texas. I began my career in the contact lens industry in 1982, working for Tex-O-Con, a large regional hard contact lens manufacturing laboratory owned by Union Corporation, which also owned Aquaflex, a Rochester-based soft lens company.

I got my feet wet in the GP industry selling Boston II lenses while they were still an FDA investigational device. Talk about an interesting selling process! Because the material was not yet FDA-approved, practitioners had to complete three forms for each patient before they were fit with a Boston II lens. They gladly did this because they knew the added oxygen delivered by this material was much healthier than PMMA, which was the primary hard lens material worn by contact lens patients in those days. I managed the West Texas/New Mexico territory.

In 1983, the company was purchased by CooperVision, where I held positions of increasing responsibility before leaving in 1988 to join Polymer Technology Corp. (PTC). My first position with PTC was as the Southwest Regional Manager. I was responsible for the authorized Boston laboratories in an 11-state region of the southwestern United States. My role expanded to include two territory managers supporting strategic markets in Texas. In 1994, I was asked to develop a national practitioner sales force to support the Authorized Boston Lab Network in promoting Boston products to practitioners in select U.S. markets. The sales force expanded from 12 to 20 sales representatives in just over 12 months. This was a great experience that provided a valuable education for me in sales management. It also provided great insights into practitioners' viewpoints and attitudes. From this position, I went on to head the North American lab channel from 1997 until October 2009, when I was offered the opportunity to head the Global GP business for Bausch + Lomb Boston. I currently serve on the Board of Directors for the Contact Lens Manufacturers Association and have done so for 7 years. I also served a 2-year term on the Board of Directors for the Contact Lens Society of America.

### **What are your responsibilities in your current position, and what is your vision for the future?**

As Director of Global Boston GP Business, I am responsible for all commercial aspects of the Boston business through the lab channel on a worldwide basis. My vision is to deliver world-class products, service and support to each of our customer segments, labs, practitioners and patients that result in the best possible outcome for the patient.

### **What do you think is the most significant recent advance in the GP industry?**

High-Dk materials, such as Boston XO<sup>®</sup> and Boston XO<sub>2</sub><sup>®</sup>, have overcome the performance issues (nonwetting, stability and deposition) that previously limited the success of higher-Dk GP materials. Practitioners have always wanted to provide the highest amount of oxygen they could, but they had to limit their material selection because of these performance issues. Overcoming these obstacles has opened the door for new categories, such as large-diameter GPs, and has improved the success rate for other categories, such as presbyopia and irregular cornea conditions.

In addition, I think the technological advances in lathing equipment, corneal topography, and fitting and lens design software have greatly increased the success rate for fitting specialty GP lenses. Many conditions or prescriptions that were considered too difficult if not impossible to fit are now very successfully fit thanks to these advances.

### **Where do you think the GP industry is headed? What changes can we anticipate in the future?**

Specialty designs are clearly the trend for GP lenses. Demographically, presbyopia is the single largest opportunity, and I think GPs will continue to capture a larger percentage of this market. Fitting irregular corneas is another opportunity. Myopia control and ortho-k lenses could provide a significant growth opportunity if the results of the SMART study demonstrate conclusively there is a myopia control effect with reverse geometry/ortho-k lenses. Another exciting area is topography-based fitting. Perfecting this approach to fitting could improve first-fit success, eliminate the need for trial lenses and allow for an unlimited combination of design parameters to fit virtually any prescription. It could also improve initial comfort, which as we all know, is the single largest objection to GP lenses.

### **What do you think is the biggest challenge facing the GP industry?**

In one word, demographics. We have an aging patient base, but of more concern is that experienced GP practitioners are aging along with the patients, and as they retire, younger fitters are not embracing GPs with the same enthusiasm.

The aging GP patient is actually an opportunity for presbyopic GP lenses as much as it is a concern. If retiring practitioners aren't replaced by new fitters, however, the industry will continue to shrink. A key to bringing new fitters into the marketplace is training and education. This is an area in which we are investing heavily through schools, supporting lab training programs, online webinars, newsletters and so on.

### **Tell us about your life outside the office. How do you like to spend your leisure time?**

My first priority is spending time with my family. I am away from home a lot, so when I'm not traveling, I like to make sure I dedicate time to my family. I love sports and outdoor activities, such as hiking, fishing and hunting when I have the time. I enjoy playing golf and coaching my son's baseball team. I'm particularly interested in history, especially the American Civil War. A lot about leadership and strategy can be learned from studying military history. I enjoy doing crossword puzzles and various other puzzles, especially math-related. ▶



### Annual Congress of the Association of Contact Lens Specialists

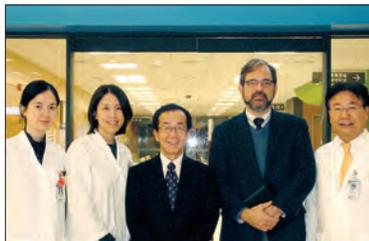
Held at the Jena University of Applied Sciences, the Annual Congress of the Association of Contact Lens Specialists attracted some 500 participants. This was the first congress that included optometrists, as this is a new profession in Germany. Left to right: Silke Lohrengel, Dieter Muckenhirn (Hecht Contactlinsen, Germany), Marcel Kopito.



### Walman/X-Cel Annual Contact Lens Seminar

More than 100 eye care practitioners and technicians attended the Walman/X-Cel Annual Contact Seminar in Orlando, Fla. Bausch + Lomb sponsored a presentation on keratoconus fitting techniques by Jason Jedlicka, OD.

### Korea Visit



Kurtis Brown and Tatsuo Harata of Bausch + Lomb Boston visit Dr. Choun-Ki Joo's clinic at The Catholic University of Korea's College of Medicine.

### Book Signing at OAA



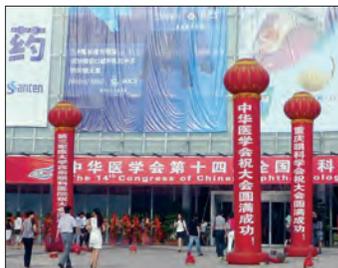
Author Nicholas Despotidis, OD, (third from right) signed his book *My Children Are Nearsighted Too!* at the Bausch + Lomb table during the 2009 meeting of the Orthokeratology Academy of America in Phoenix, Ariz.

### B+L Workshop at University of Houston



Attendees at a CKR seminar and fitting workshop for Vision Shaping Treatment.

### 14th Congress of China Ophthalmological Society



More than 100 doctors attended an orthokeratology training session sponsored by Autek Hefei during the 14th Congress of China Ophthalmological Society.



David Bland, Tatsuo Harata and Jim Lunkley meet with Jason and Jerry Wu at TMVC in Taipei.

### Vision Expo West



John Hibbs (right) with Ken Crawford, TruForm Optics.

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