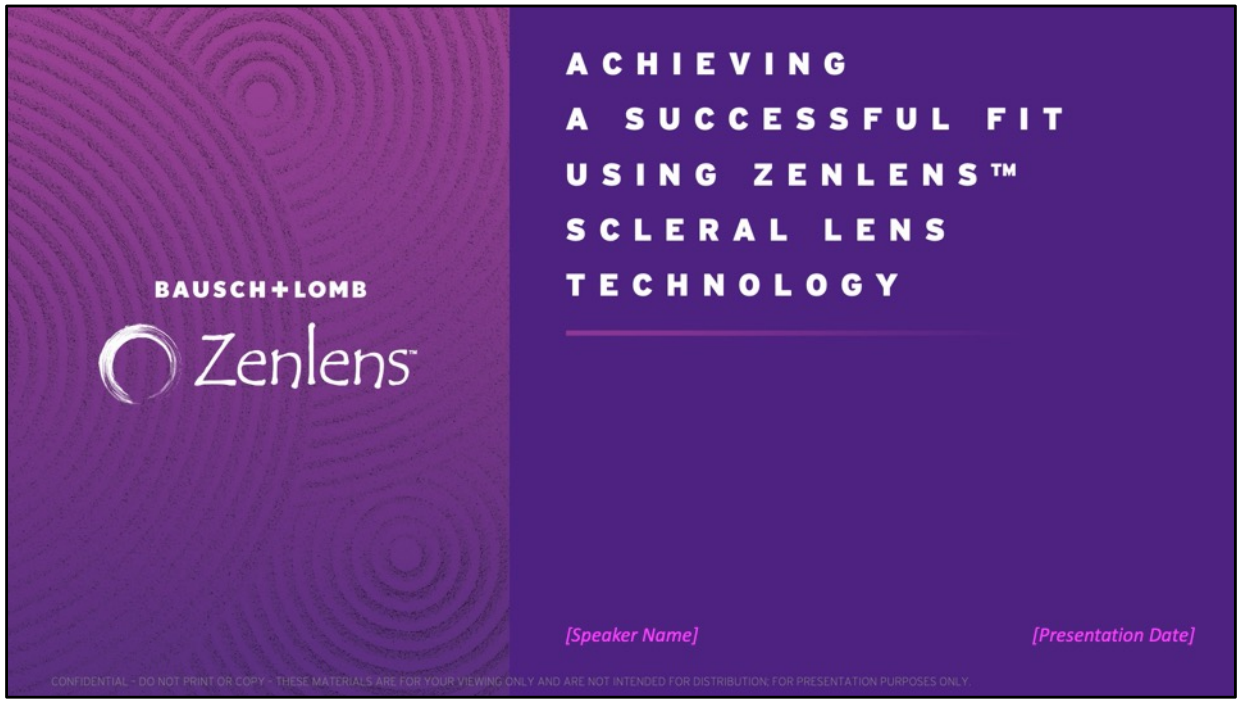
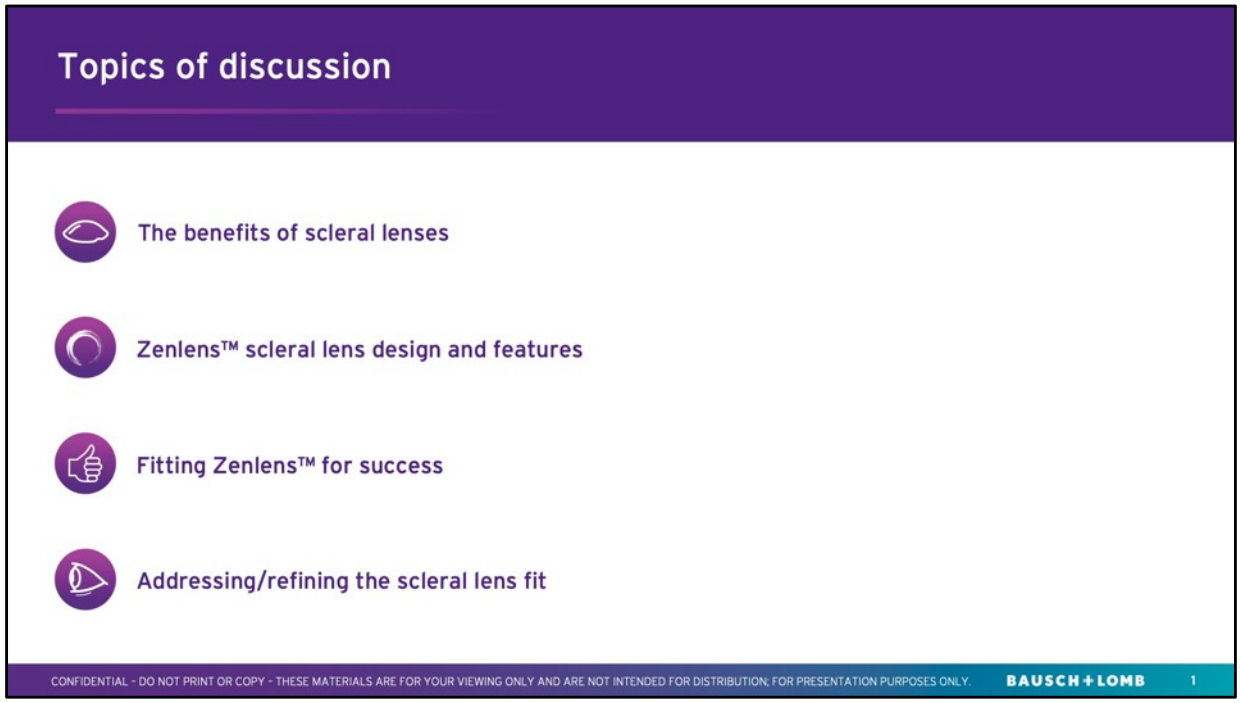


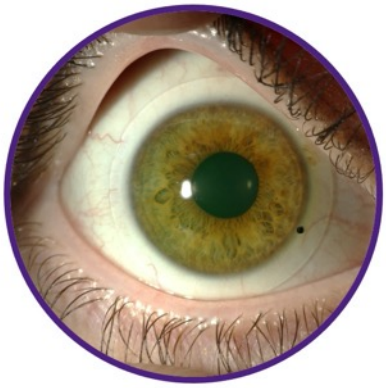
- Introduce yourself and the program.



- In today's presentation, I will be discussing:
- The benefits of scleral lenses
- Zenlens™ scleral lens design and features
- Fitting Zenlens™ for success
- Addressing/refining the scleral lens fit
- *First, let's get into some of the benefits of scleral lenses*


THE BENEFITS OF SCLERAL LENSES

The benefits of scleral lenses



Comfort[1]

No corneal contact
Lands on scleral conjunctiva

Vision correction[1,2]

Corrects both normal and irregular corneas

On-eye centration and stability[1]

Better lens centration and stability compared to corneal lenses on eyes with irregular corneal surfaces

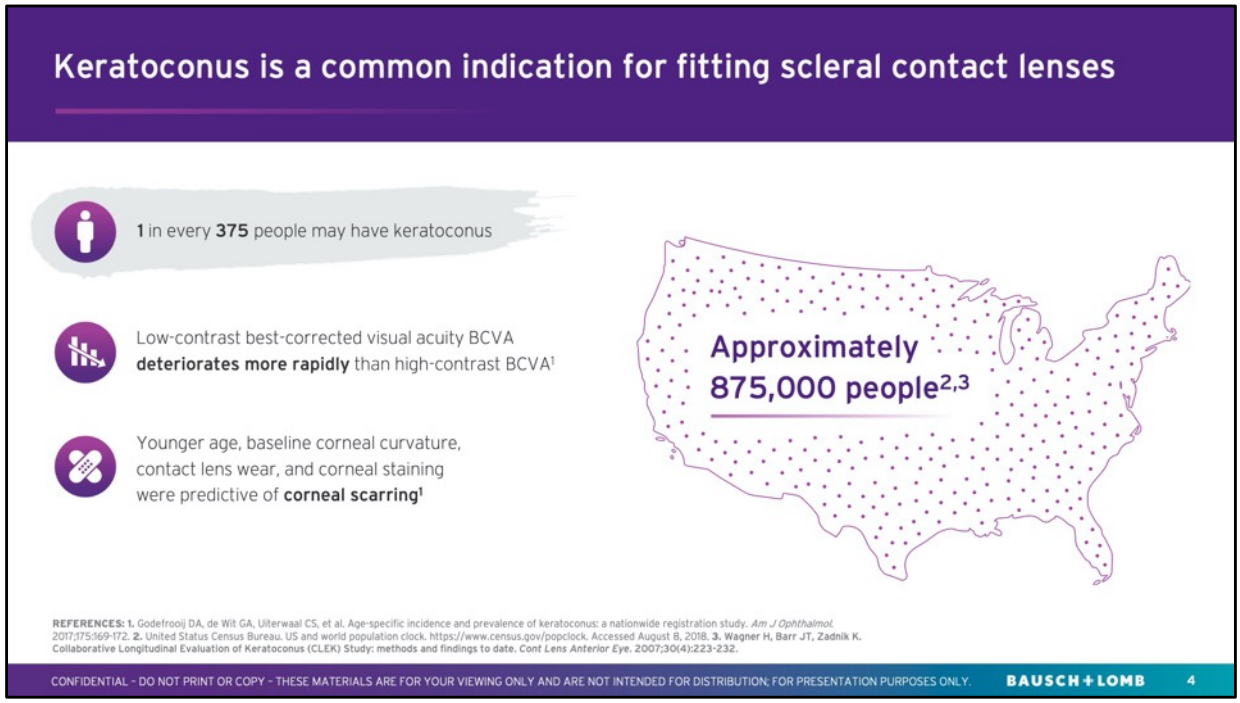
Ocular surface protection[1]

Creates a tear reservoir between the lens and the ocular surface

REFERENCES: 1. Schornak M. Medical indications for scleral lens use. In: Barnett M, Johns LK, eds. *Ophthalmology: Current and Future Developments. Volume 4. Contemporary Scleral Lenses: Theory and Application.* Sharjah, UAE: Bentham Science Publishers; 2017. **2.** Michaud L. Scleral lenses for the regular/normal/non-diseased cornea. In: Barnett M, Johns LK, eds. *Ophthalmology: Current and Future Developments. Volume 4. Contemporary Scleral Lenses: Theory and Application.* Sharjah, UAE: Bentham Science Publishers; 2017.

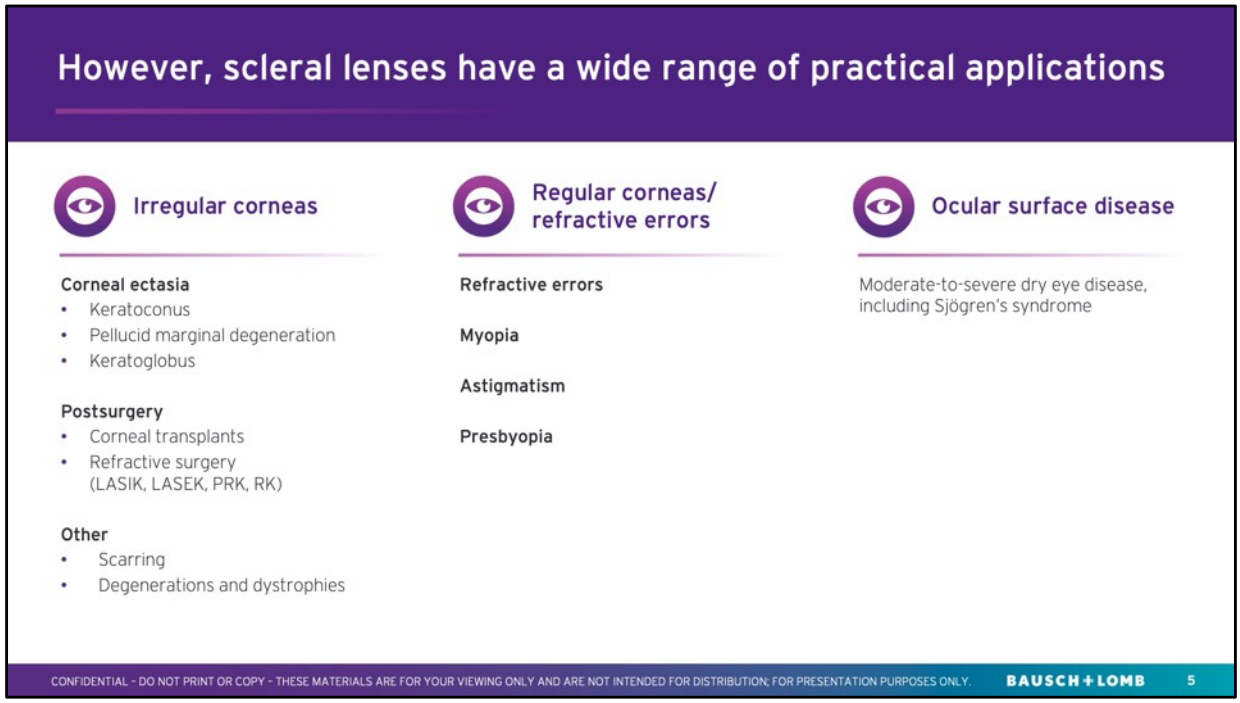
Key Talking Points:

- Scleral lenses offer a variety of benefits to patients, including comfort, centration and stability, vision correction, and ocular surface protection



Key Talking Points:

- One in every 375 people in the United States may have keratoconus; this equates to ~875,000 people
- Patients with keratoconus may have low-contrast best-corrected visual acuity (BCVA) that deteriorates more rapidly than high-contrast BCVA
- For patients with keratoconus, younger age, baseline corneal curvature, contact lens wear, and corneal staining were predictive of corneal scarring
- While keratoconus is a highly common indication and often a primary reason for fitting scleral contact lenses, there are many other conditions and situations where scleral lenses can be used effectively

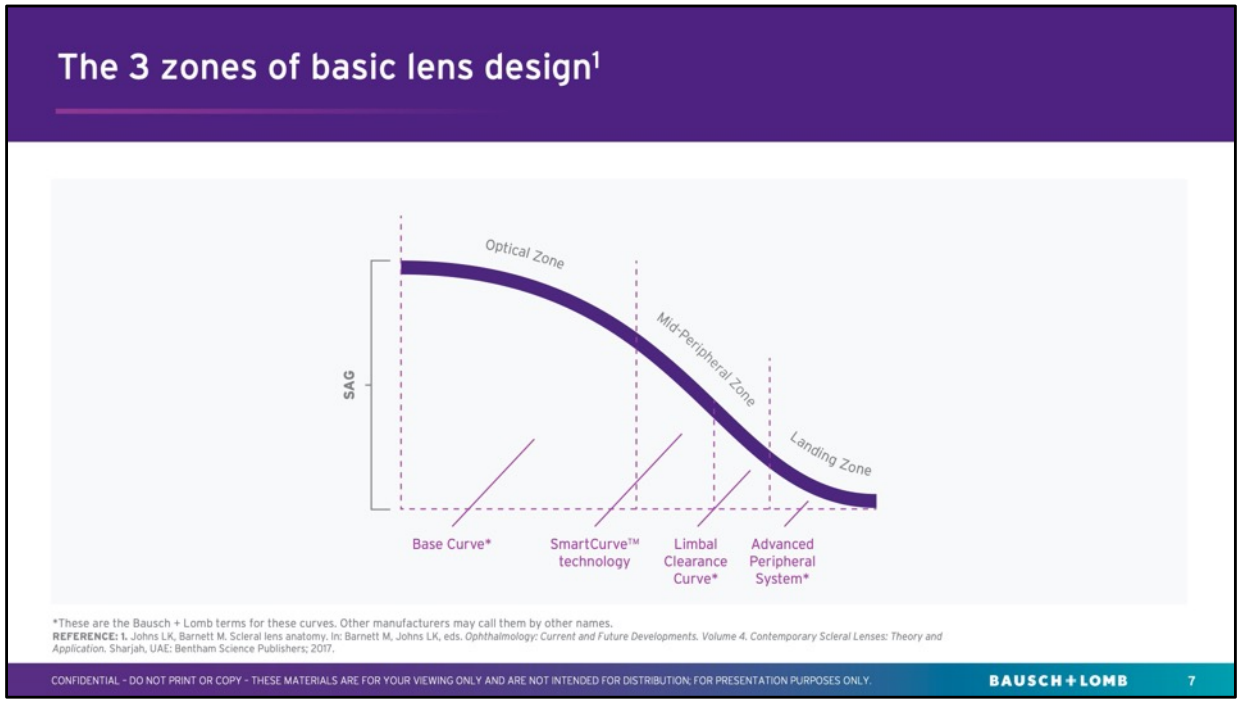


Key Talking Points:

- For use with irregular corneas in addition to keratoconus and other corneal ectasias, scleral lenses are also practical for postsurgery patients
- Postsurgical irregular corneas can result from corneal transplants and refractive surgery
- Other causes of irregular corneas include scarring or degeneration and dystrophies
- When fit correctly, scleral contact lenses can provide treatment for refractive errors and post-keratoplasty astigmatism.
- In addition to irregular corneas, scleral lenses can be used on regular corneas, which include those with refractive errors, myopia, astigmatism, and presbyopia
- Multifocal scleral lenses can be an option for patients who are not satisfied with their soft multifocal lenses
- Lastly, corneas with ocular surface disease may also be suitable for scleral lenses
- This includes moderate-to-severe dry eye disease, including Sjögren's syndrome, Stevens-Johnson syndrome, graft-vs-host disease, exposure keratopathy, ocular cicatricial pemphigoid, neurotrophic corneal disease, limbal stem cell deficiency, and atopic keratoconjunctivitis
- It is estimated that 6.8% of the adult (>18 years of age) population has been diagnosed with Dry Eye Disease. This is equal to 16.4 million people
- Approximately half of these people have moderate-to-severe dry eye disease (42%

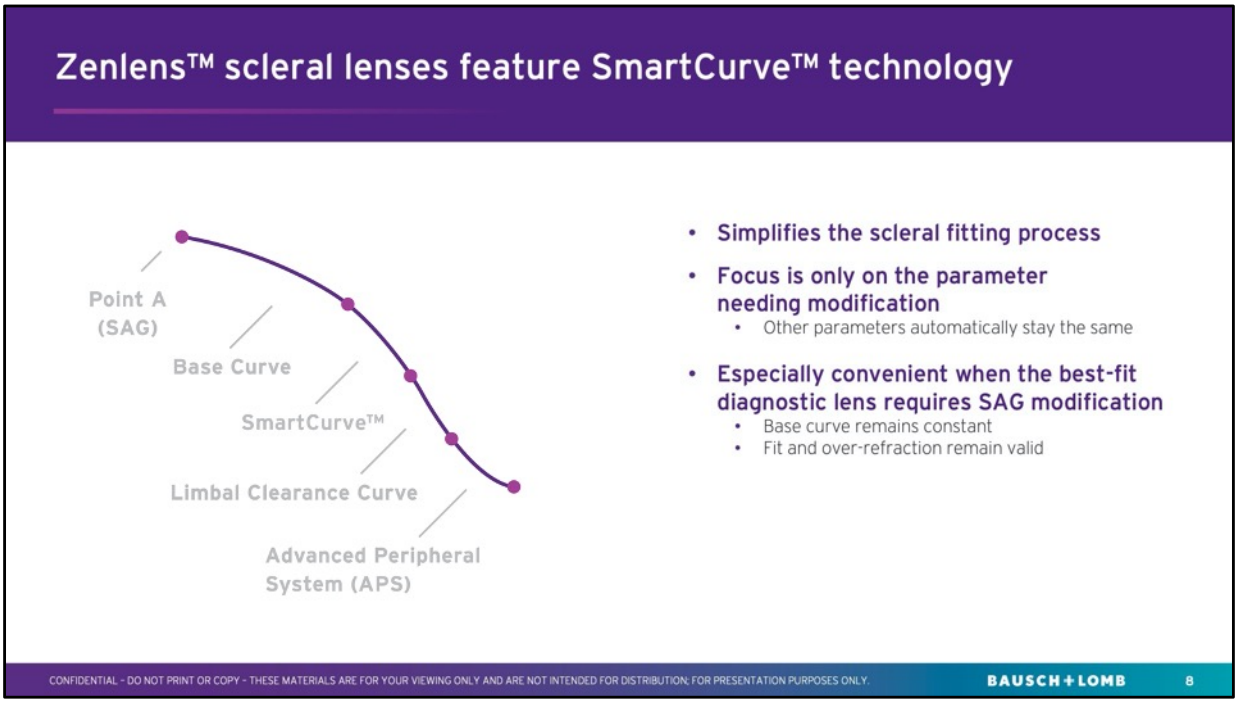
moderate, 8% severe)


ZENLENS™ SCLERAL LENS
DESIGN AND FEATURES



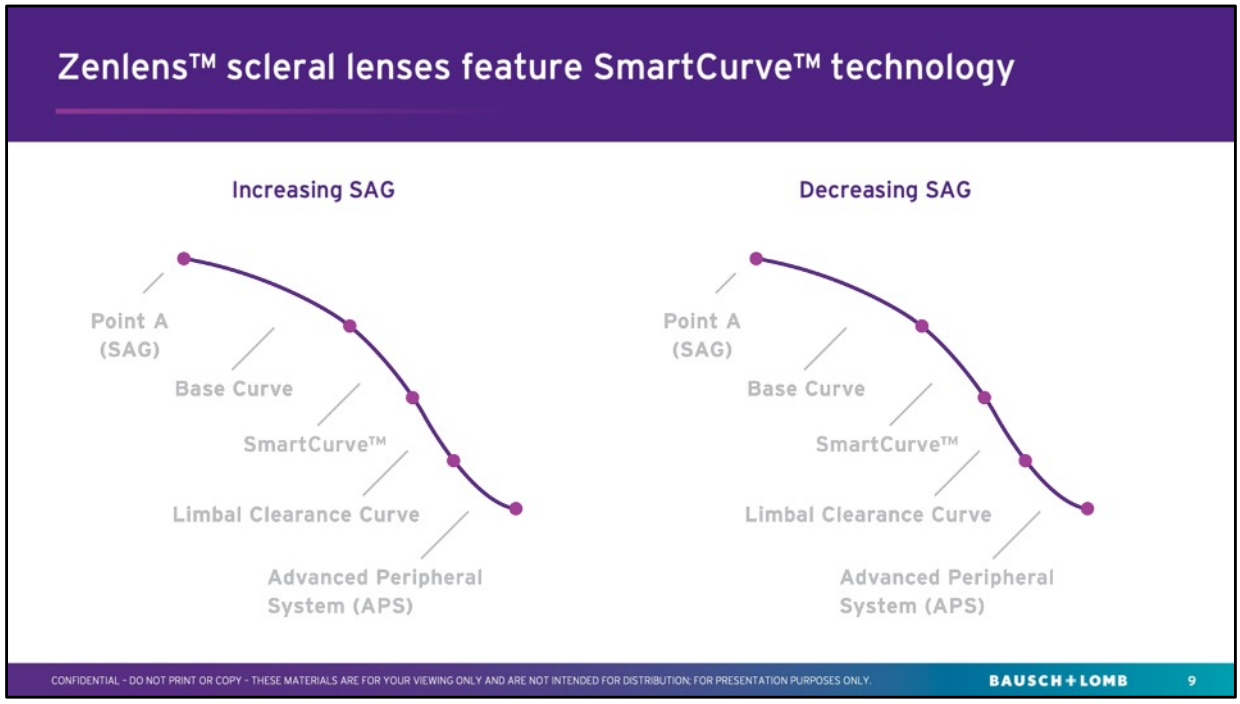
Key Talking Points:

- There are 3 zones in a basic scleral lens design:
    - The optical zone
    - The mid-peripheral zone
    - The landing zone
- The clearance is the space between the cornea and the back surface of the lens that vaults over the cornea, which is a different measurement than the sagittal height/depth
- Each manufacturer may call the curves by different names. These are the terms used for Bausch + Lomb scleral lenses:
    - Base curve: optical zone
    - SmartCurve™ and limbal clearance curve: mid-peripheral zone
    - Advanced Peripheral System: landing zone



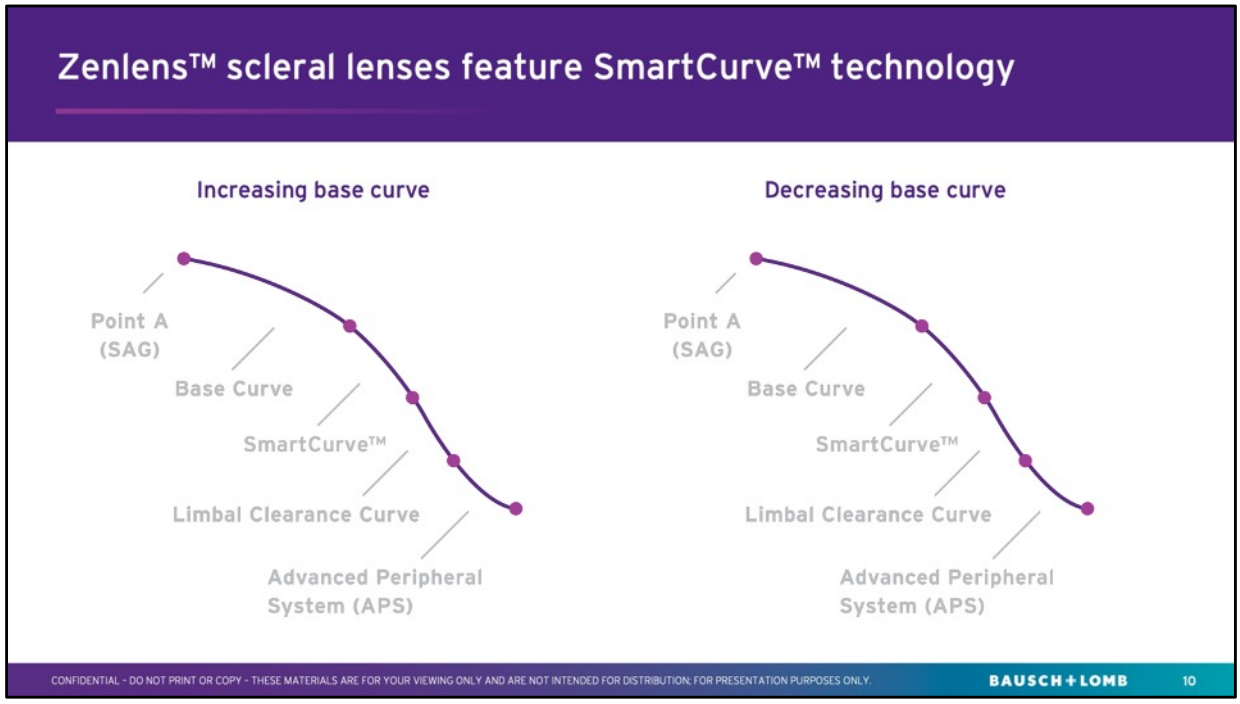
Key Talking Points:

- SmartCurve™ is the unique and proprietary technology used in Zenlens™ that enables you to modify parameters with precision. When a parameter is modified, SmartCurve™ technology automatically adapts to ensure most other design attributes remain consistent
- Point A represents the deepest point of the lens or central sagittal height
- The SmartCurve™ itself is based on a mathematical equation and cannot be adjusted by the practitioner
- In this example, you'll see the SmartCurve™ adjusting without impacting the rest of the curvature of the lens



Key Talking Points:

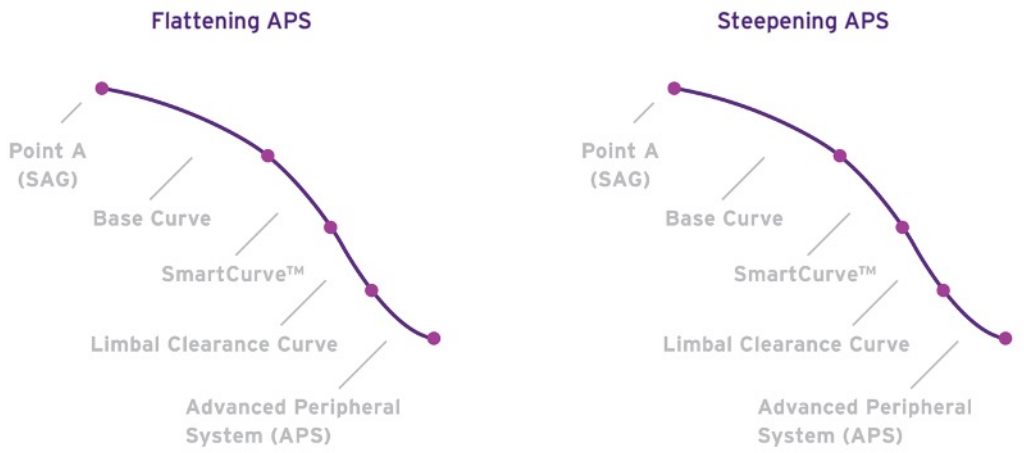
- In this example, you'll see the lens SAG increasing on the left, and decreasing on the right, without impacting the rest of the lens



Key Talking Points:

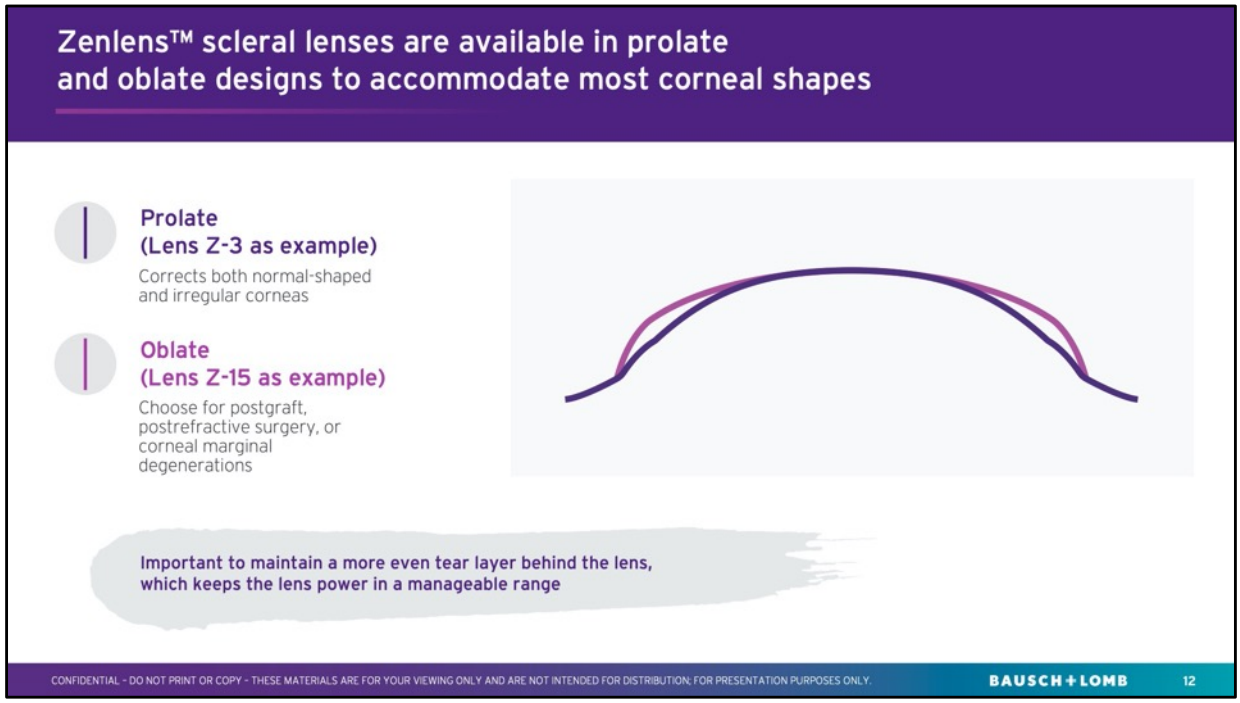
- In this example, you'll see the base curve increasing on the left, and decreasing on the right, without impacting the rest of the lens

Zenlens™ scleral lenses feature SmartCurve™ technology



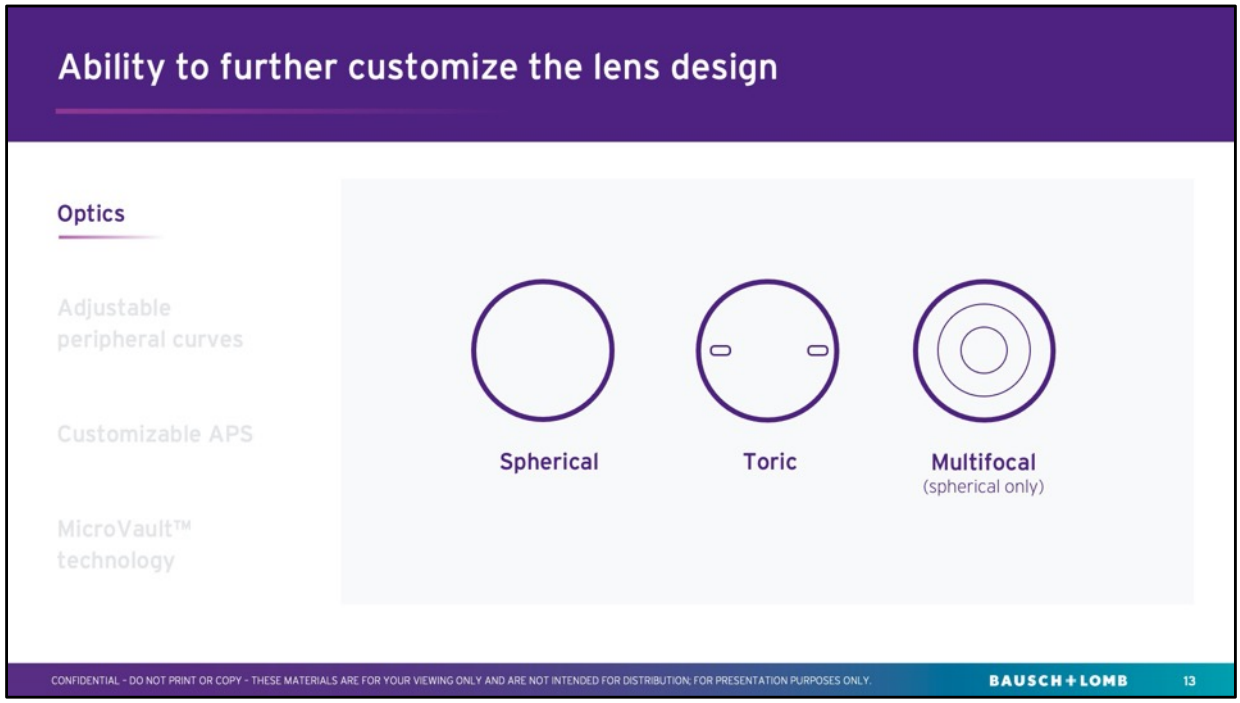
Key Talking Points:

- In this example, you'll see the APS flattening on the left, and steepening on the right, without impacting the rest of the lens



Key Talking Points:

- This is an example of how the prolate shape compares to the oblate shape
- Prolate lenses have central base curves that are steep, relative to a flatter periphery
- Oblate lenses have central base curves that are flat, relative to a steeper periphery
- For example, you may choose the prolate design for keratoconus or normal-shaped corneas with ocular surface disease. Or you may choose the oblate design for postgraft, postrefractive surgery, or corneal marginal degenerations

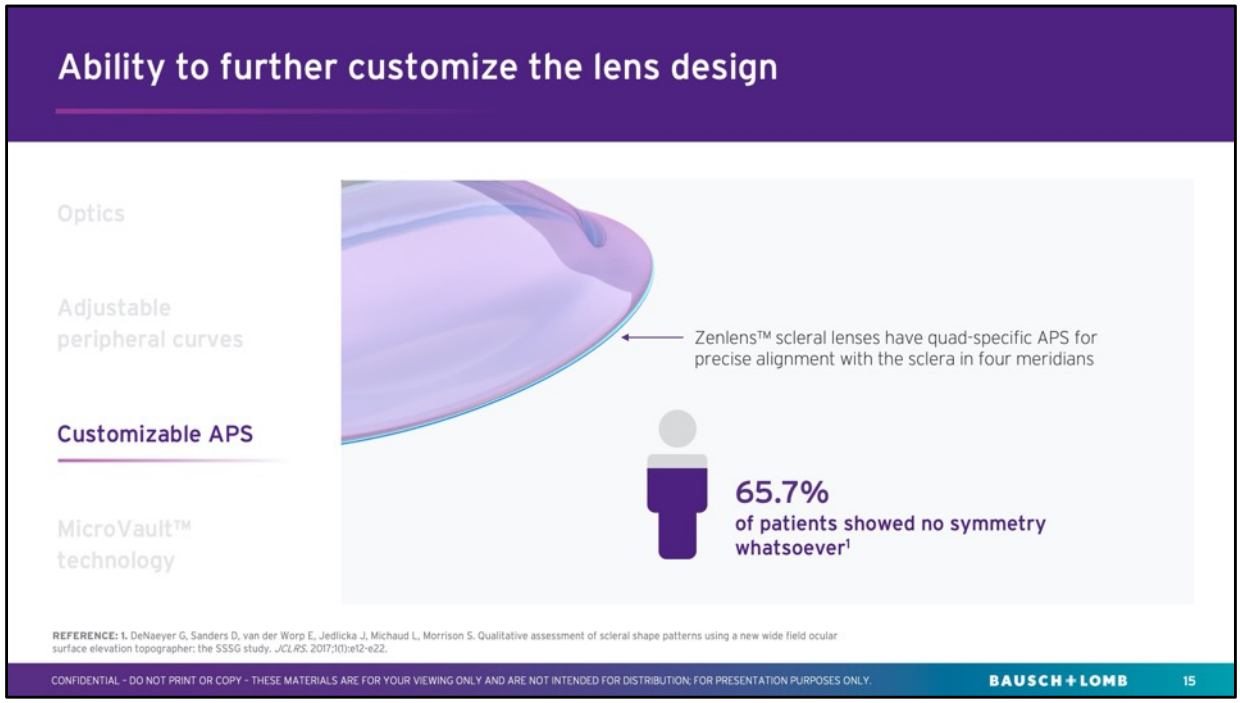


Key Talking Points:

- If toric Rx is needed for vision, front toric optics can be added to the anterior optic zone
- Multifocal is an option as well and can be used with any diameter size. We will discuss more about the multifocal design and fitting later in this presentation

Key Talking Points:

- Adjustable peripheral curves help with limbal clearance and can address any limbal bearing you may observe
- When fitting Zenlens™ scleral lenses, the lens should exhibit clearance beyond the limbus. If a lens does not demonstrate full limbal clearance, ask for an increased limbal clearance as a custom parameter when ordering, or possibly move to a larger diameter lens



Key Talking Points

- Scleral profilometry, or topography, evaluated scleral shape and showed that the sclera is highly irregular. In a study by DeNaeyer, et al, only 5.7% of scleras were spherical in shape. 40.7% had asymmetric high points (or elevations) or asymmetric low points (or depressions), and 25% had a recognizable toric pattern with elevations and depressions, but they were irregularly spaced or did not have the customary 180° periodicity
- Zenlens™ has a generous landing zone that, when properly fit, reduces air bubbles, lens impingement, and conjunctival impression rings
- Can be ordered flatter or steeper
- Quadrant-specific edge lifts maintain alignment with the sclera in four meridians—which is helpful, as a majority of patients show no symmetry (DeNaeyer, et al)
- For example, if you see bubbles under the lens, you may need to check for edge lift in one or more quadrants and may require toric or steeper APS
- For blanching or redness, you may need to flatten the APS. But if blanching or redness occurs in opposing meridians, consider toric APS

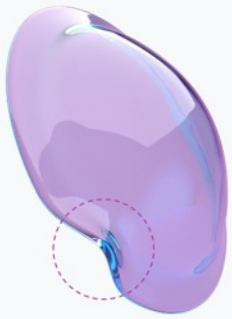
Ability to further customize the lens design

Optics

Adjustable peripheral curves

Customizable APS

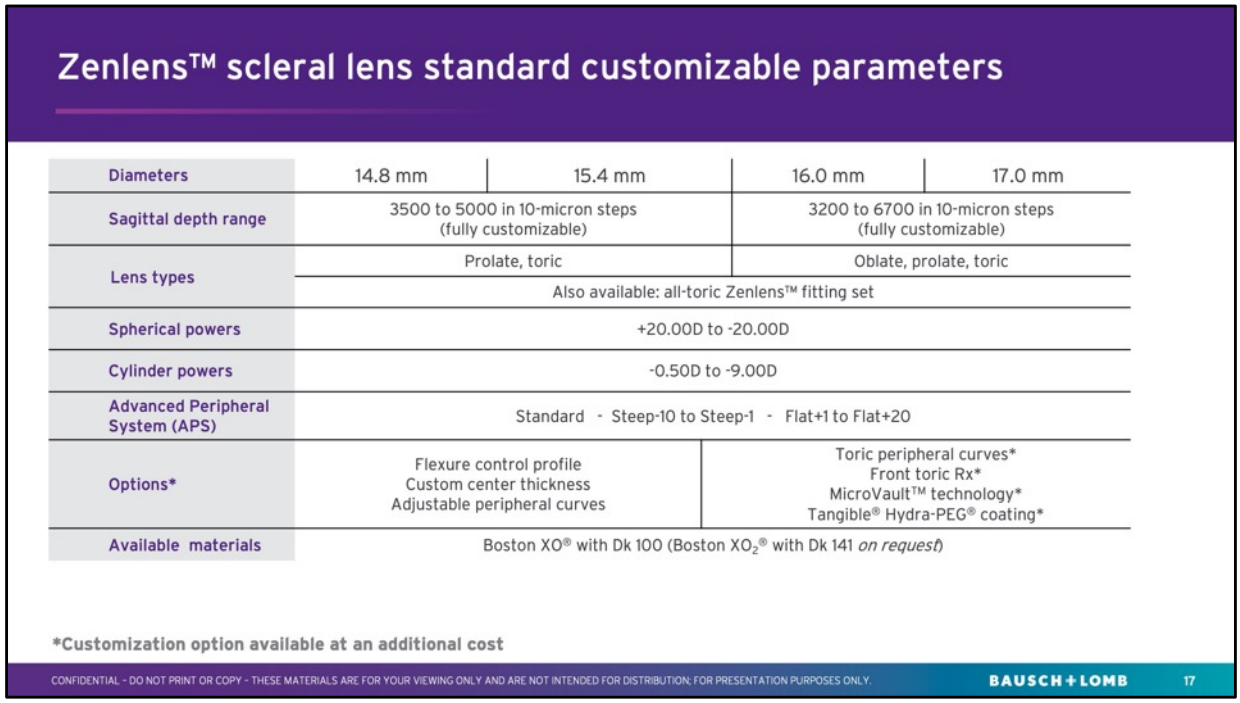
MicroVault™ technology



- Creates a precisely designed elevation to vault the lens over a peripheral obstruction
- Designed and manufactured with CAD/CAM technology
- Enables precision and reproducibility compared with hand notching

Key Talking Points:

- Creates a precisely designed elevation to vault the lens over a peripheral obstruction
- Designed and manufactured with CAD/CAM technology
- Enables precision and reproducibility compared with hand notching
- Consultants can support non-edge peripheral elevations
- MicroVault™ technology can be applied to any design that has stabilization



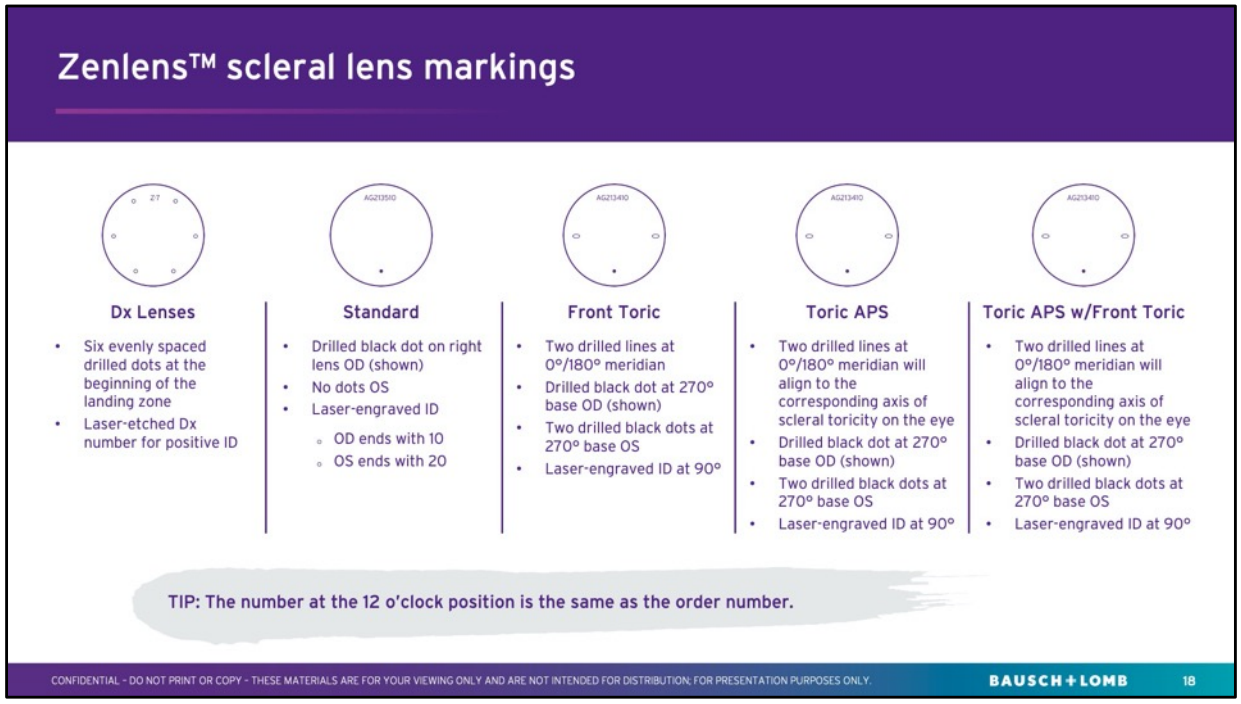
Key Talking Points:

- Zenlens™ comes in 4 diameters—14.8 mm, 15.4 mm, 16.0 mm, and 17.0 mm—to help fit a range of patient eyes and conditions
- Zenlens™ also offers an all-toric fitting set if that is an option you would prefer
- It includes a variety of features and options that helps enable a successful fit to each unique patient's needs

For instance, select lens diameter based on corneal diameter measurement or estimation:

• For smaller corneas (11.7-mm HVID or smaller), the 16.0-mm design is recommended

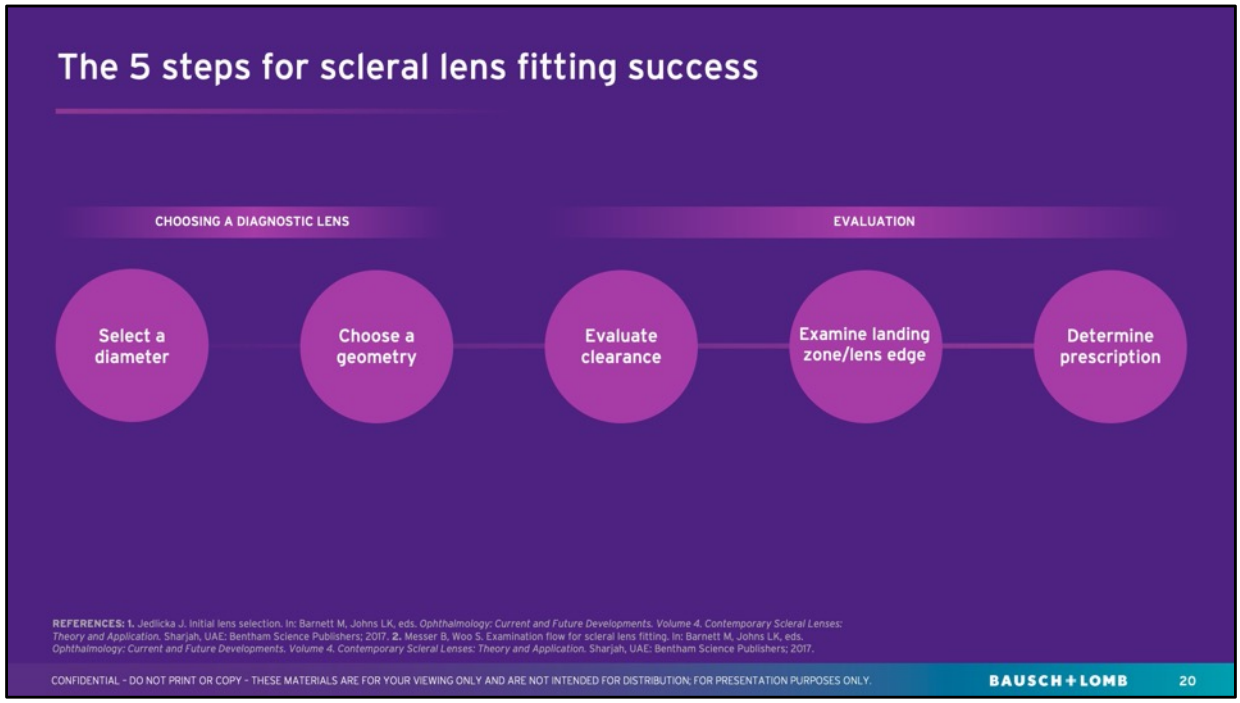
• For larger corneas (11.8-mm HVID or larger), the 17.0-mm design is recommended



Key Talking Points:

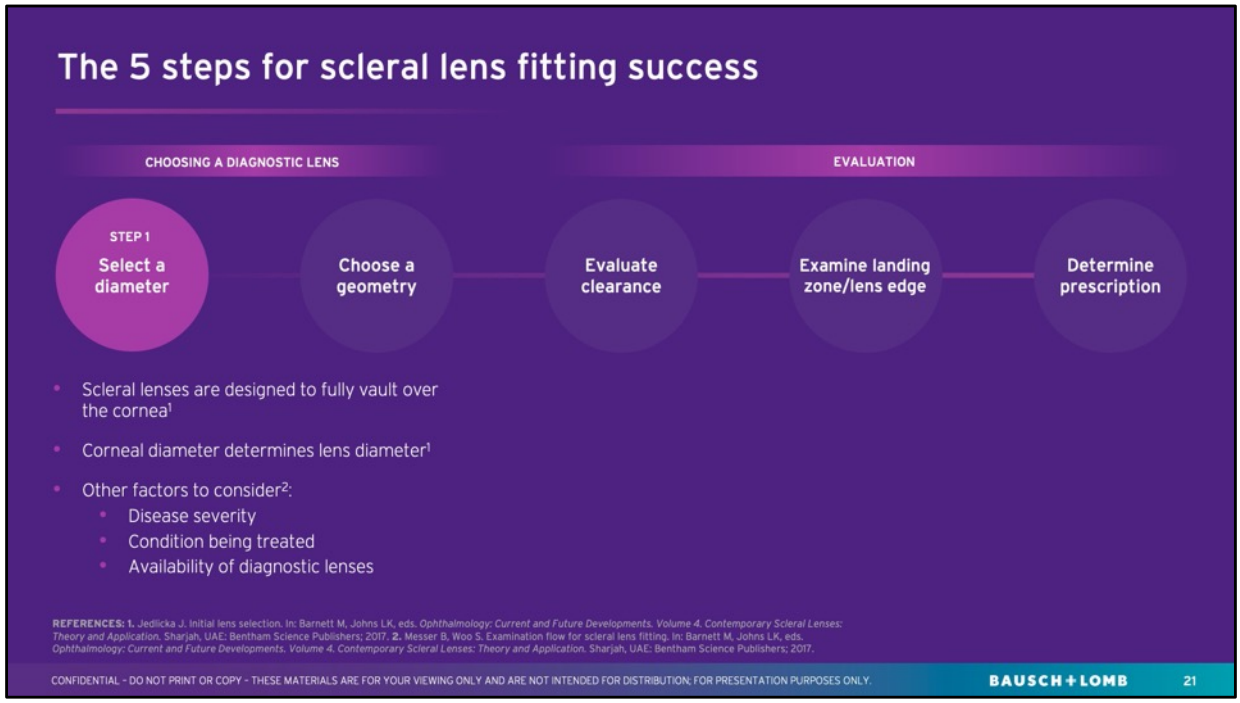
- Each Zenlens™ lens has distinct markings that make it easier to clearly identify the lens type
- Each also has a diagnostic number on it as well
- The **drilled marking** on toric and multifocal lenses can help guide patient insertion


FITTING FOR SUCCESS



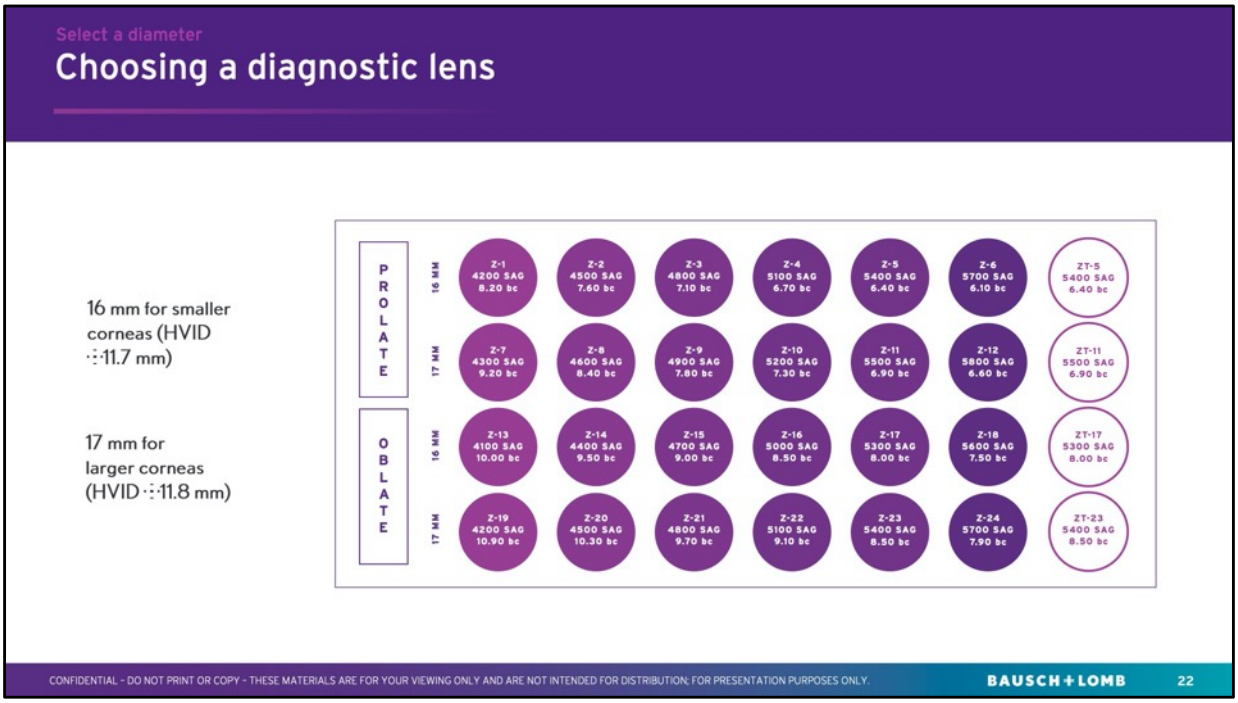
Key Talking Points:

- These are the 5 fundamental steps for scleral lens fitting success
- There are additional nuances to these steps (eg, material selection, surface treatments) that are not covered in this presentation



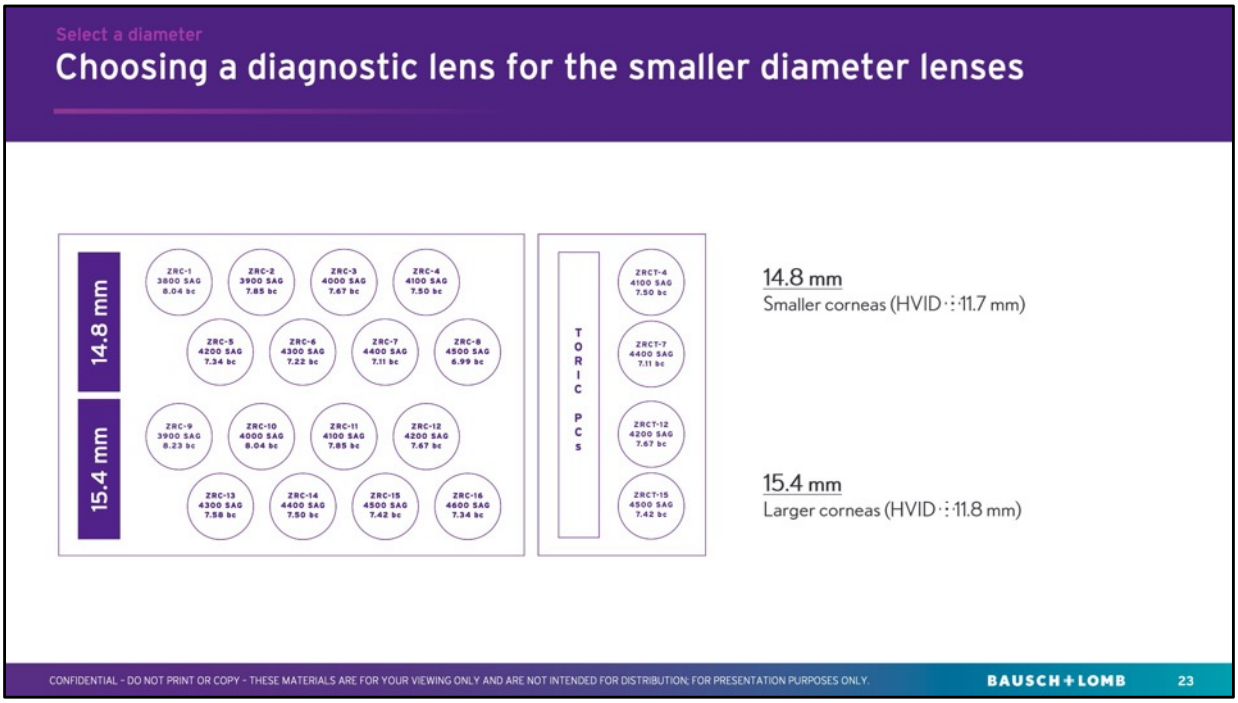
Key Talking Points:

- While these are the 5 fundamental steps to fitting a scleral lens, there are additional nuances to these steps (e.g., material selection, surface treatments) that are not covered in this presentation
- The first step in fitting a scleral lens is to select a diameter
- Scleral lenses are designed to fully vault over the cornea and limbus to land on the sclera. Therefore, corneal diameter determines the lens diameter
- Other factors to consider when choosing a lens diameter are disease severity, the condition being treated, and the availability of diagnostic lenses



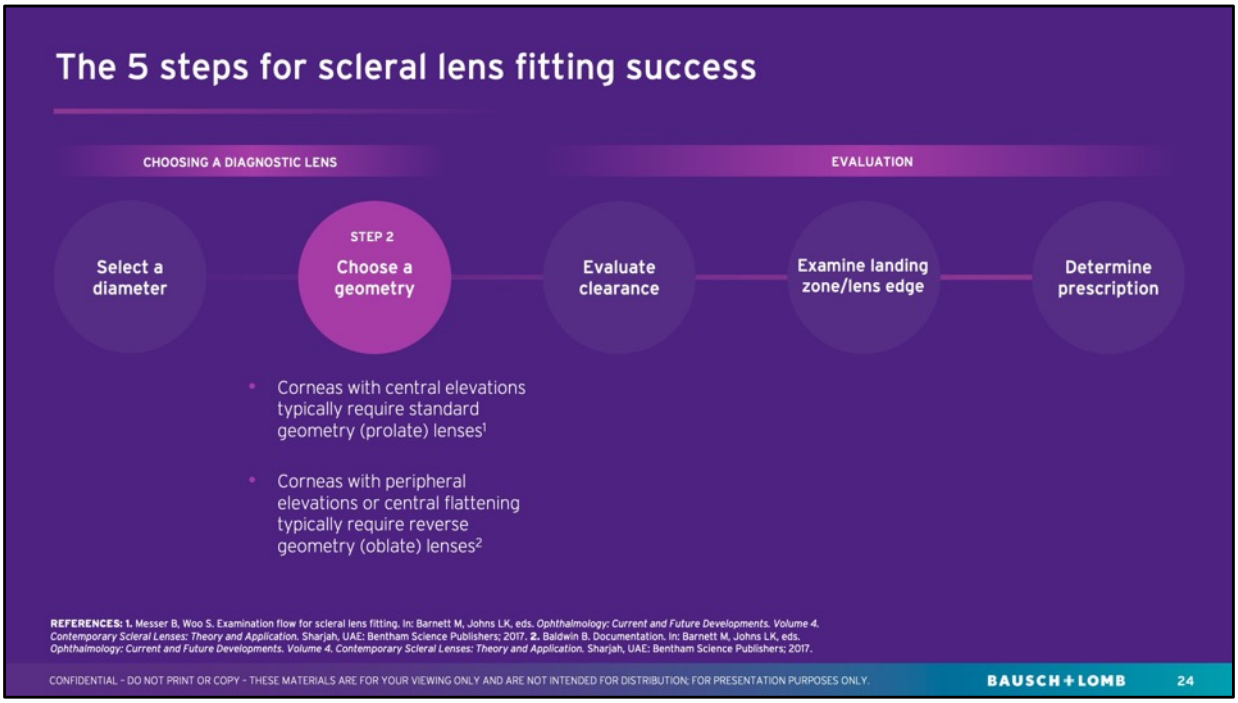
Key Talking Points:

- It is important to follow these fitting suggestions to obtain a good fit
- 16-mm lenses are suitable for a smaller cornea with a horizontal visible iris diameter that is equal to or less than 11.7 mm
- If the sagittal height with a 16-mm lens is good but the diameter is too small, choose the 17-mm lens that is to the left of the original 16-mm lens. For instance, if the sagittal height of the Z-3 lens is good but the diameter is too small, try the Z-8 lens instead. This preserves the sagittal height while increasing the diameter of the lens
- 17-mm lenses are suitable for larger corneas with a horizontal visible iris diameter that is equal to or more than 11.8 mm
- Both prolate and oblate shapes come in 16-mm and 17-mm diameters



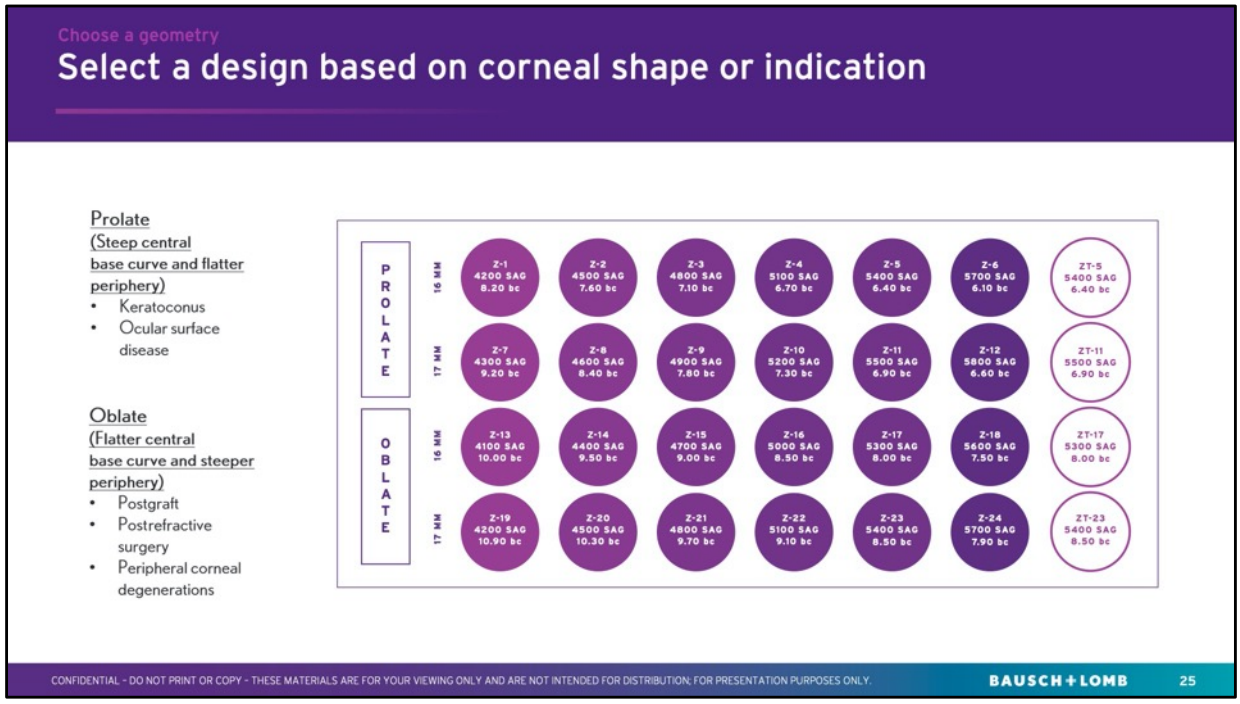
Key Talking Points:

- 14.8 mm lenses are suitable for a smaller cornea with a horizontal visible iris diameter that is equal to or less than 11.7 mm
- 15.4 mm lenses are suitable for a larger cornea with a horizontal visible iris diameter that is equal to or more than 11.8 mm



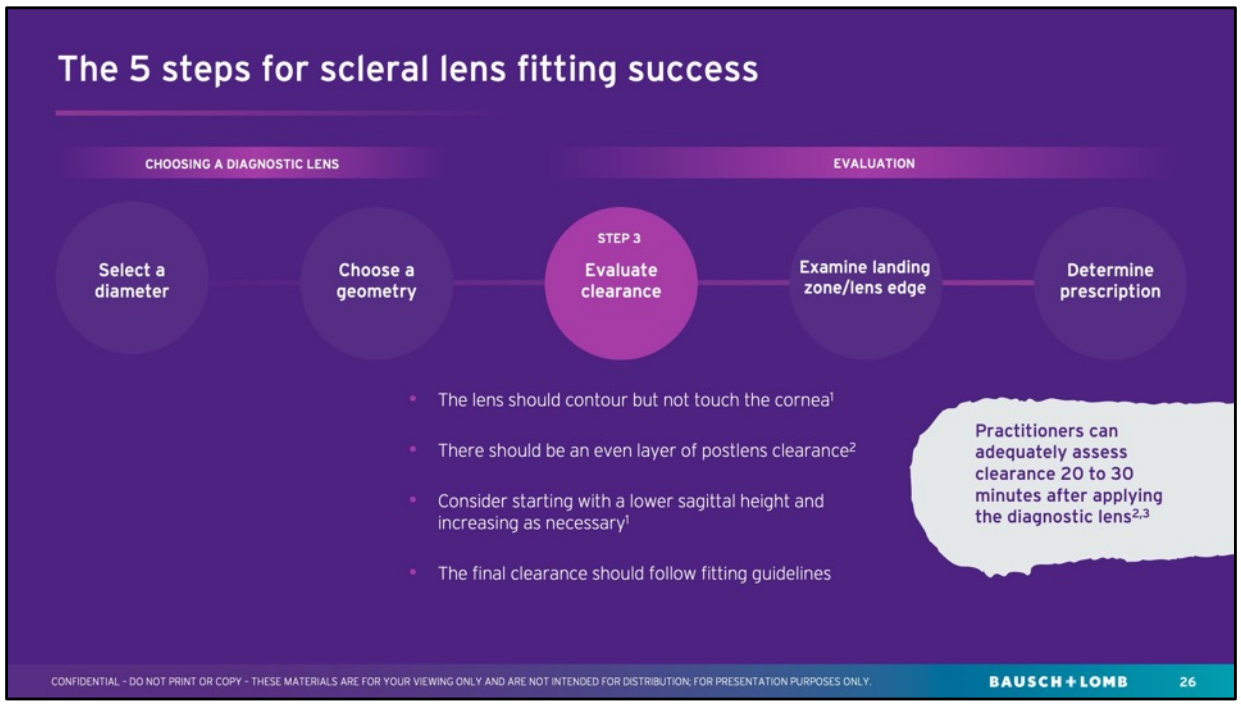
Key Talking Points:

- The second step in fitting a scleral lens is to choose a geometry (prolate vs oblate)
    - Corneas with central elevations typically require standard geometry (prolate) lenses
    - Corneas with peripheral elevations or central flattening typically require reverse geometry (oblate) lenses
- Power considerations for each lens geometry are also important because the base curve is partly responsible for the effective power



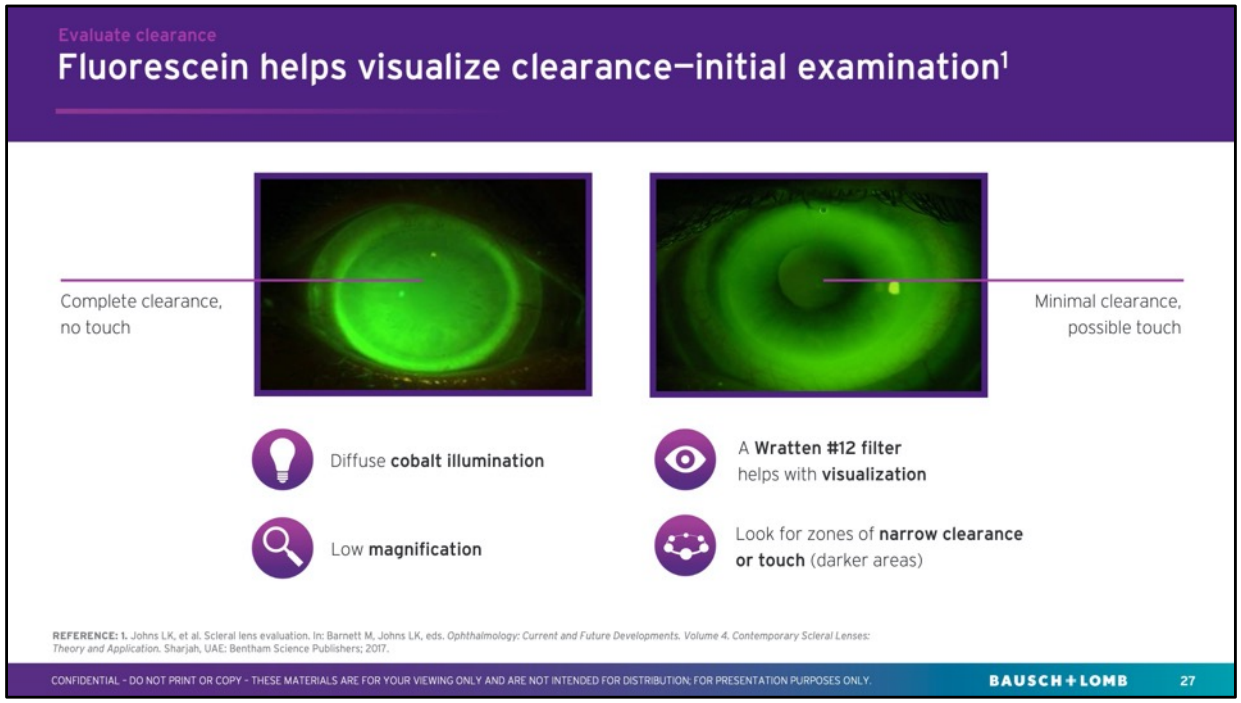
Key Talking Points:

- Prolate shapes have central base curves that are steep, relative to a flatter periphery. This geometry is recommended for keratoconus and ocular surface disease
- Oblate lenses have a central base curve that is flat, relative to a steeper periphery. This geometry is recommended for postgraft corneas, postrefractive surgery corneas, and peripheral corneal degenerations
- Oblate lenses may not suit all postgraft corneas. Consider cornea shape before fitting an oblate lens



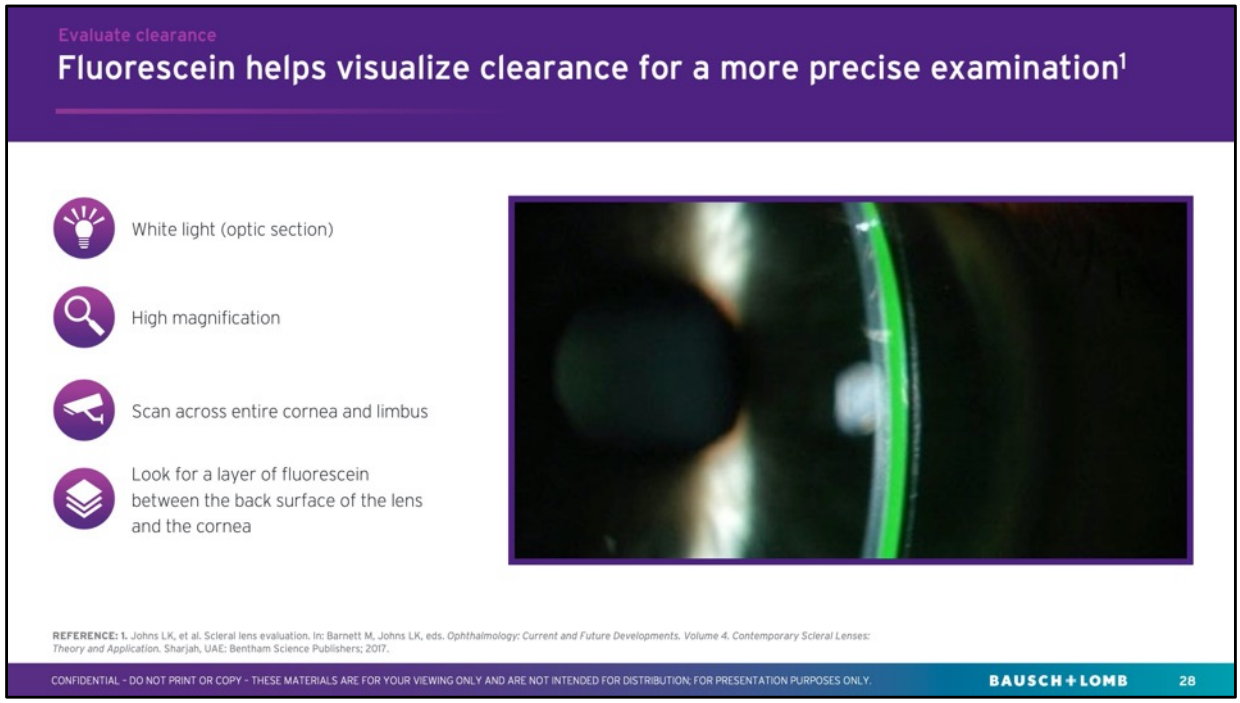
Key Talking Points:

- The lens should contour but not touch the cornea, and, when possible, there should be an even layer of postlens clearance
- Lenses should be fitted to allow for clearance. If there is insufficient clearance, the sagittal height and/or limbal clearance should be increased to take into account further settling with longer wear times
- The final clearance for the lens should follow its fitting guidelines
- Scleral lenses need time (20 to 30 minutes) to settle into the conjunctiva, so waiting to assess clearance is important. Some practitioners may choose to wait up to 60 minutes or more for the lens to settle



Key Talking Points:

- Fluorescein can be used to assess clearance. Areas of minimal, narrow clearance or possible touch will appear as darker areas, whereas complete clearance will be illustrated by complete fluorescein
- When assessing clearance, diffuse cobalt illumination, low magnification, and a Wratten #12 filter will help with visualization



Key Talking Points:

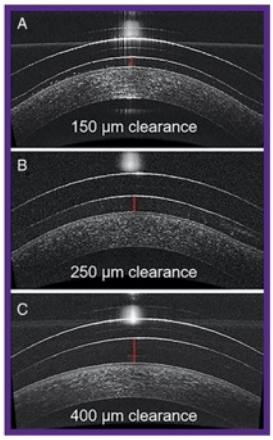
- Areas of narrow clearance or possible touch can be further examined with a narrow beam of white light (optic section) under high magnification
- The entire cornea and limbus should be scanned for clearance
- In areas of clearance, a layer of fluorescein should be visible between the back surface of the lens and the cornea
- The amount of clearance can be quantified by comparing the known thickness of the lens with the tear layer behind the lens

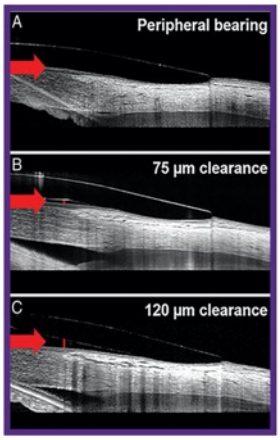
Evaluate clearance

Viewing central and limbal clearances with OCT

Example OCT line scan images demonstrating variation in initial central clearance for various miniscleral contact lenses of different sagittal depths fitted to a normal cornea

A: 150-microns
B: 250-microns
C: 400-microns apical clearance



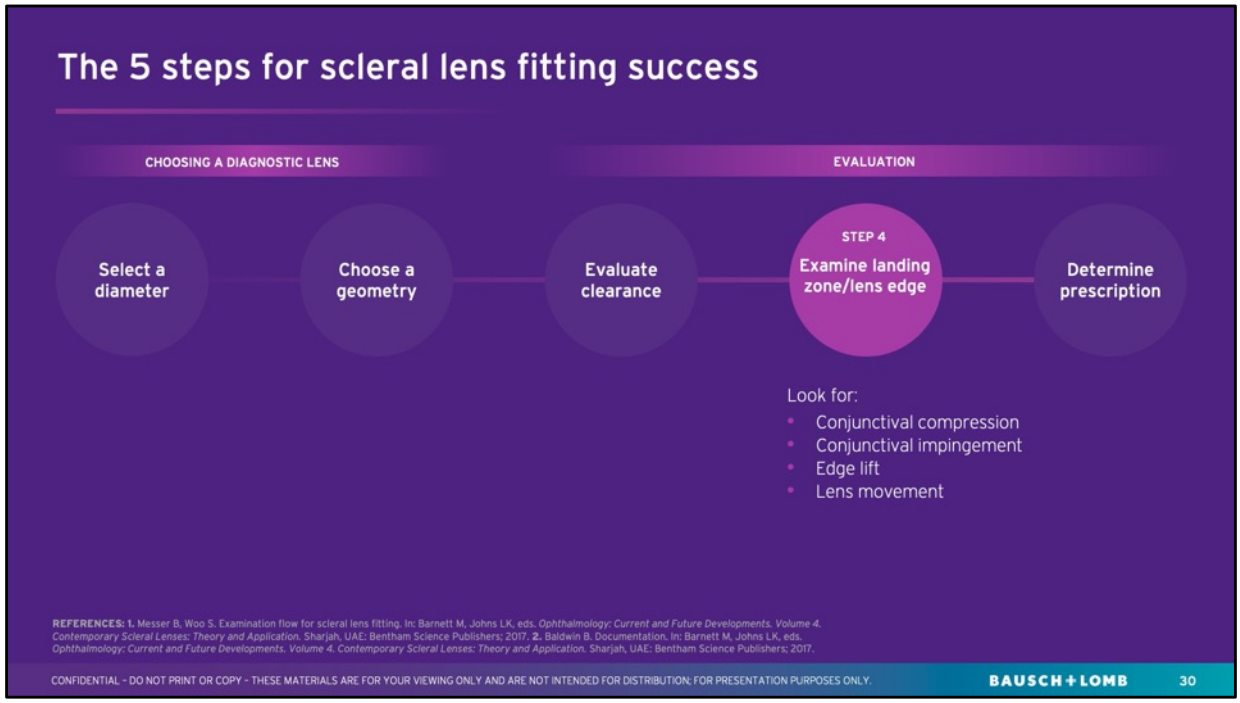


Example OCT images highlighting variations in peripheral, corneal, and limbal clearance in the same eye for alternative lens designs

A: Peripheral lens bearing
B: 75-microns
C: 120-microns limbal clearance

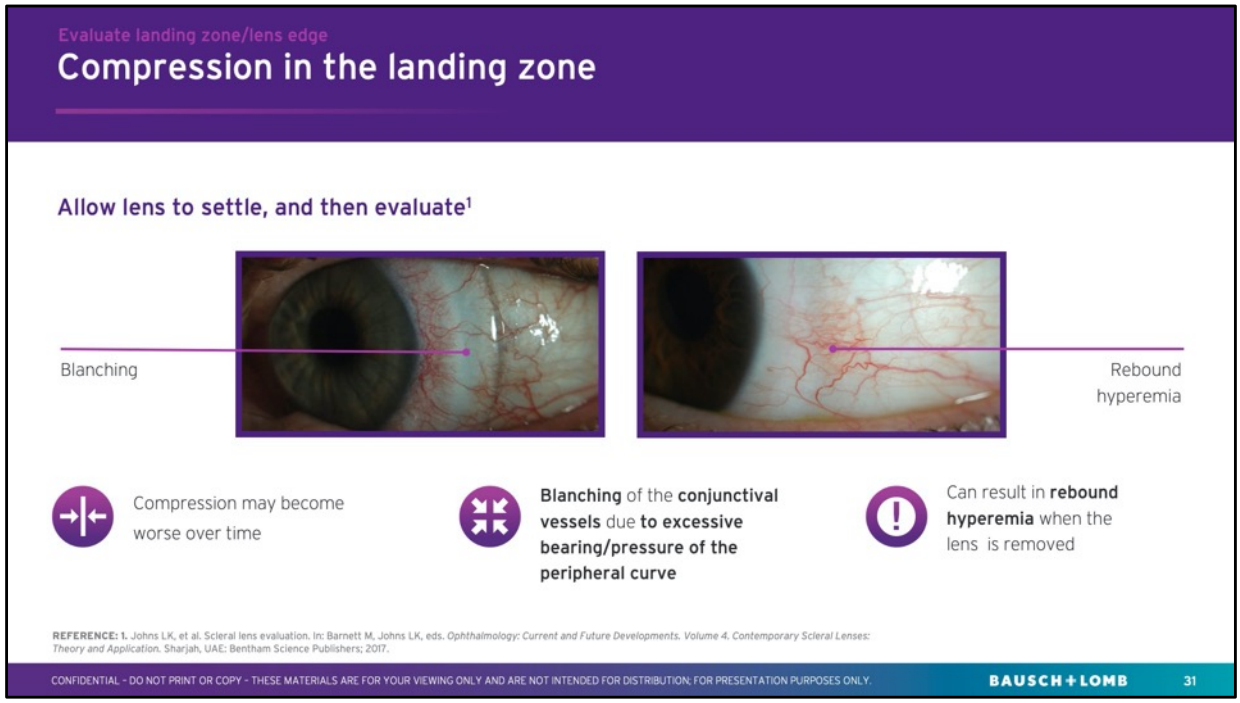
Key Talking Points:

- Although an OCT image is being used on this slide, indicate that, on the patient's first return to the office after the initial lens is dispensed, it is possible and suggested to evaluate the lens using fluorescein with the slit lamp



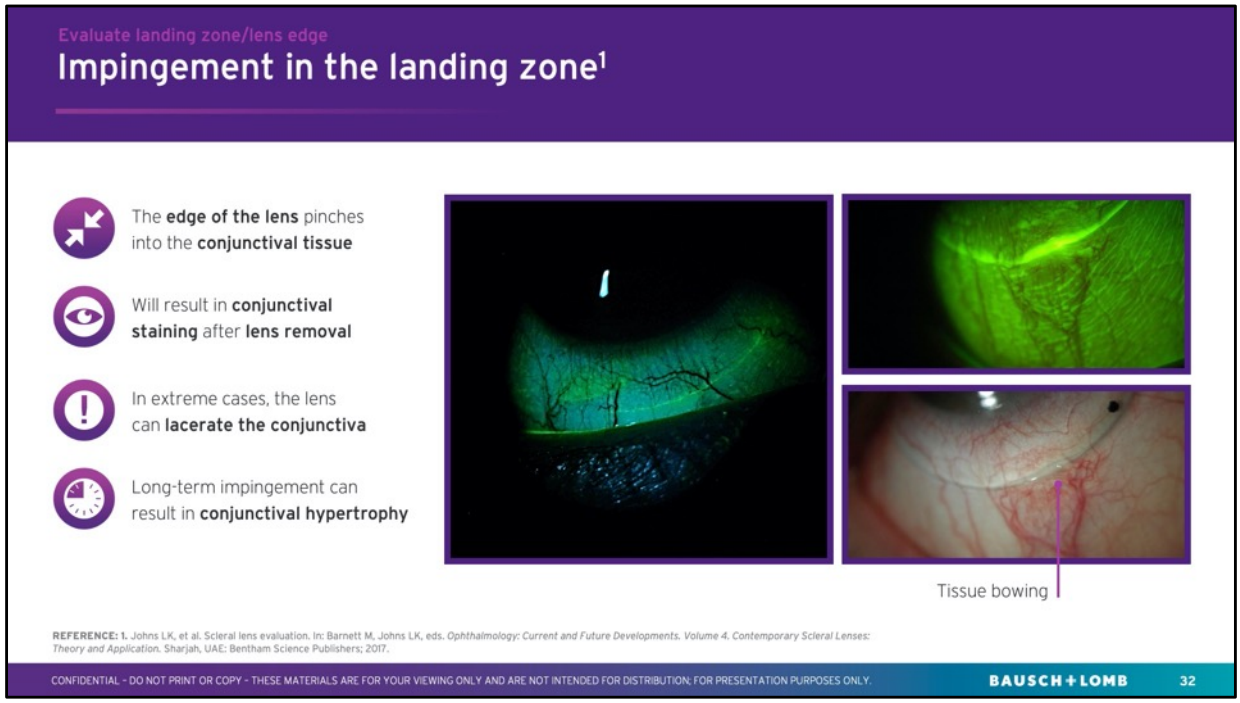
Key Talking Points:

- After allowing time for the lens to settle for 20 to 30 minutes during the initial fitting visit, the landing zone and lens edge should be examined
- During follow-up visits, the lens should be allowed to settle for at least 4 hours before the examination occurs
- The lens should be evaluated for conjunctival compression, conjunctival impingement, edge lift, and lens movement



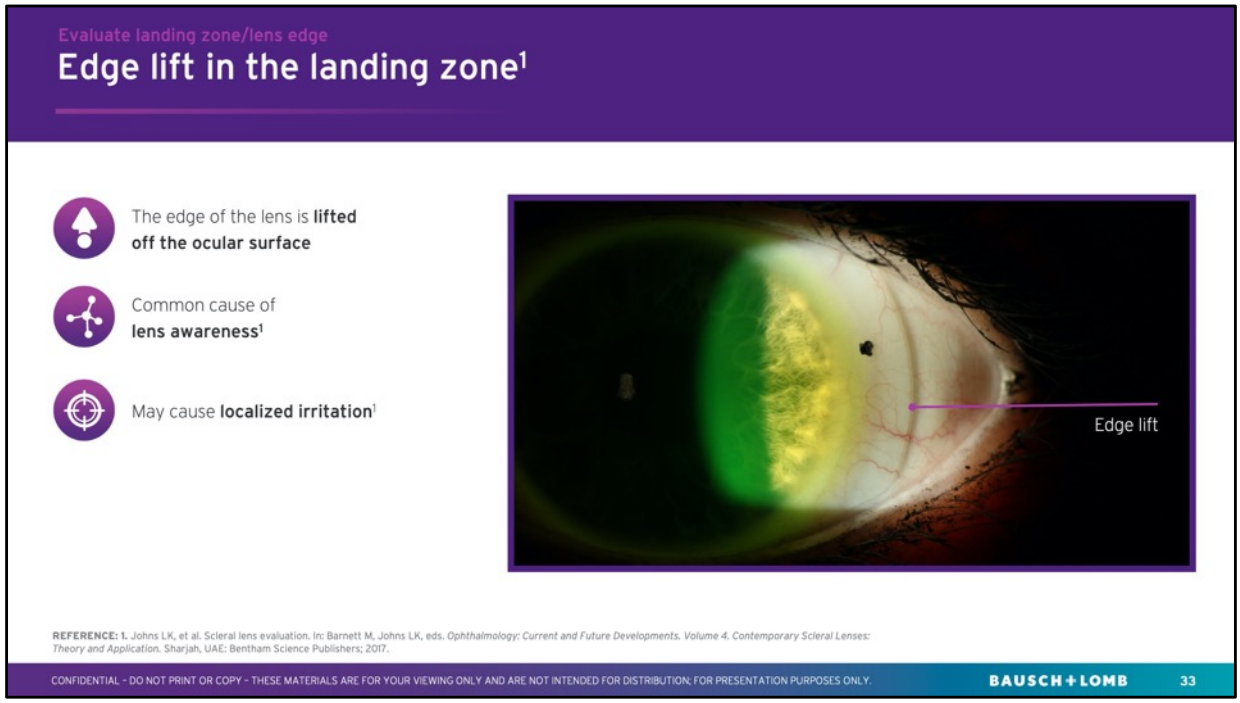
Key Talking Points:

- Compression may become worse over time, so during the initial fitting visit, patients should be evaluated after wearing the lens for 20 to 30 minutes
- During follow-up visits, the lens should be allowed to settle for at least 4 hours before the examination occurs
- Compression will be visible as blanching of the conjunctival vessels, and can result in rebound hyperemia when the lens is removed.
- Blanching may happen in the “toe and/or heel” areas of the landing zone. Blanching’s location is critical to describe when calling in to consultation
- Landing zone compression can be resolved by redesigning the landing zone
- Compression in the midperiphery of the landing zone may require the far peripheral curves to be steepened and/or the curves closest to the transition to be flattened
- Patients with compression usually complain of tightness and/or tiredness and experience immediate relief after lens removal



Key Talking Points:

- Impingement is usually a result of a very steep landing zone, where only the very edge of the lens is in contact with the conjunctiva.
- When using fluorescein during the fitting process, after the lens is removed, the conjunctiva may become readily stained with fluorescein indicating impingement
- Can be hard to detect. A subtle observation is that the adjacent tissue outside of the edge of the lens may bow forward.
    - In extreme cases, the lens can lacerate the conjunctiva
    - Long-term impingement can result in conjunctival hypertrophy
- Patients complain of discomfort and tenderness, often accompanied by tearing on lens removal. Symptoms usually worsen throughout wearing time
- Can be relieved by lifting the lens edge away from the scleral surface via either flattening the peripheral curves or increasing edge lift

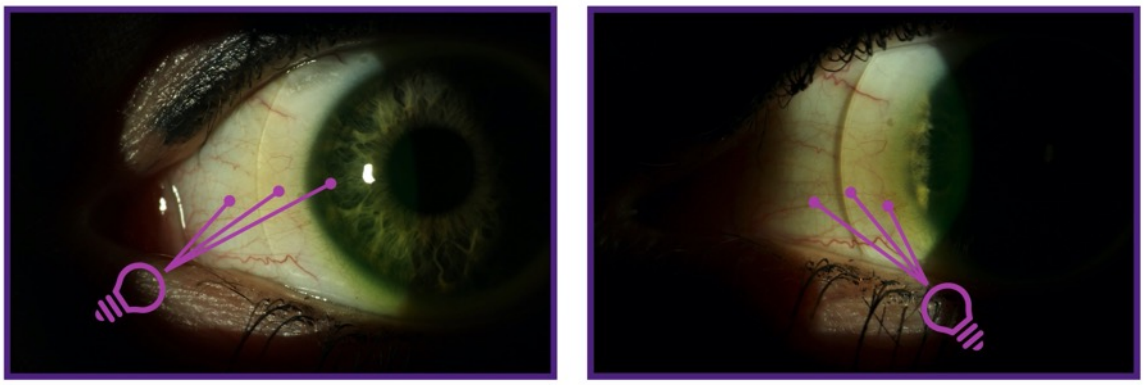


Key Talking Points:

- Edge lift occurs when the edge of the lens is lifted off of the ocular surface
- Patients may complain of lens awareness that could manifest as a “tight” sensation, irritation, or sharpness. These complaints can direct the practitioner to areas of concern

Evaluate landing zone/lens edge

Slit-lamp evaluation of edge lift[1]



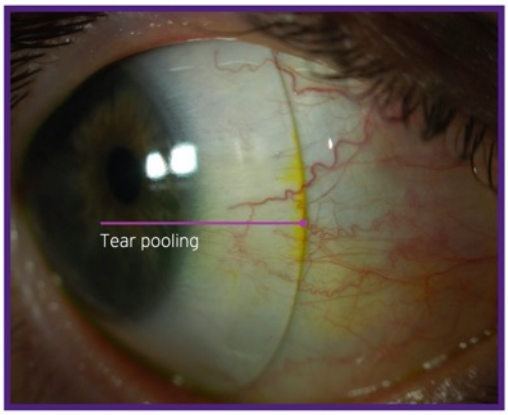
REFERENCE: 1. Johns LK, et al. Scleral lens evaluation. In: Barnett M, Johns LK, eds. *Ophthalmology: Current and Future Developments. Volume 4. Contemporary Scleral Lenses: Theory and Application.* Sharjah, UAE: Bentham Science Publishers; 2017.

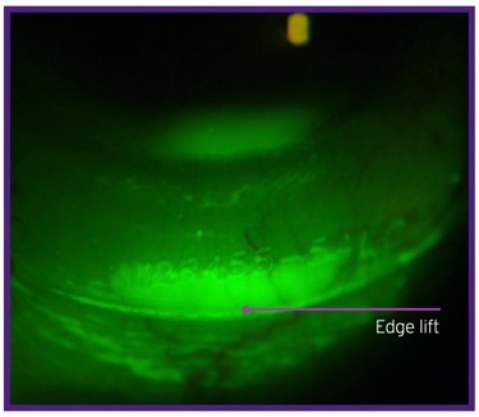
Key Talking Points:

- To look for subtle edge lift, the slit lamp is positioned perpendicularly to the edge of the lens, while the light source is placed at a 45° angle to the slit lamp
- If there is edge lift at the 12 o'clock and 6 o'clock positions, there is often light compression 90° away at the 3 o'clock and 9 o'clock positions

Evaluate landing zone/lens edge

Fluorescein helps identify edge lift[1]





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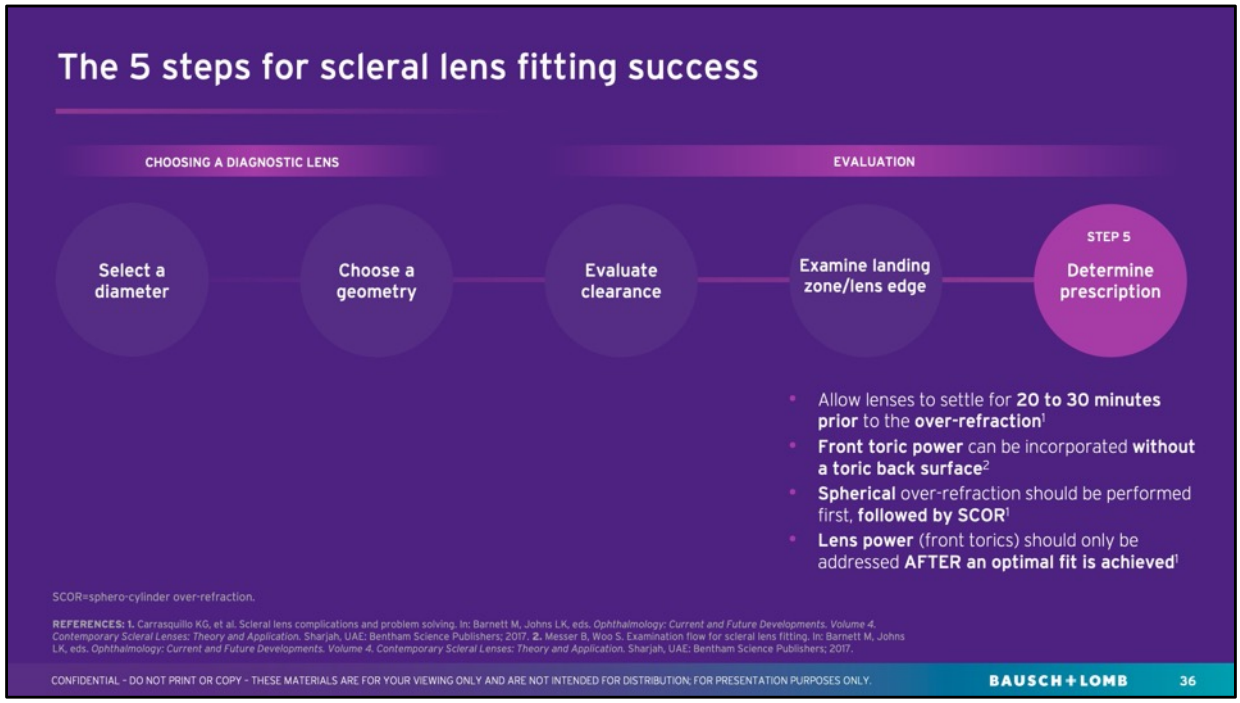
Key Talking Points:

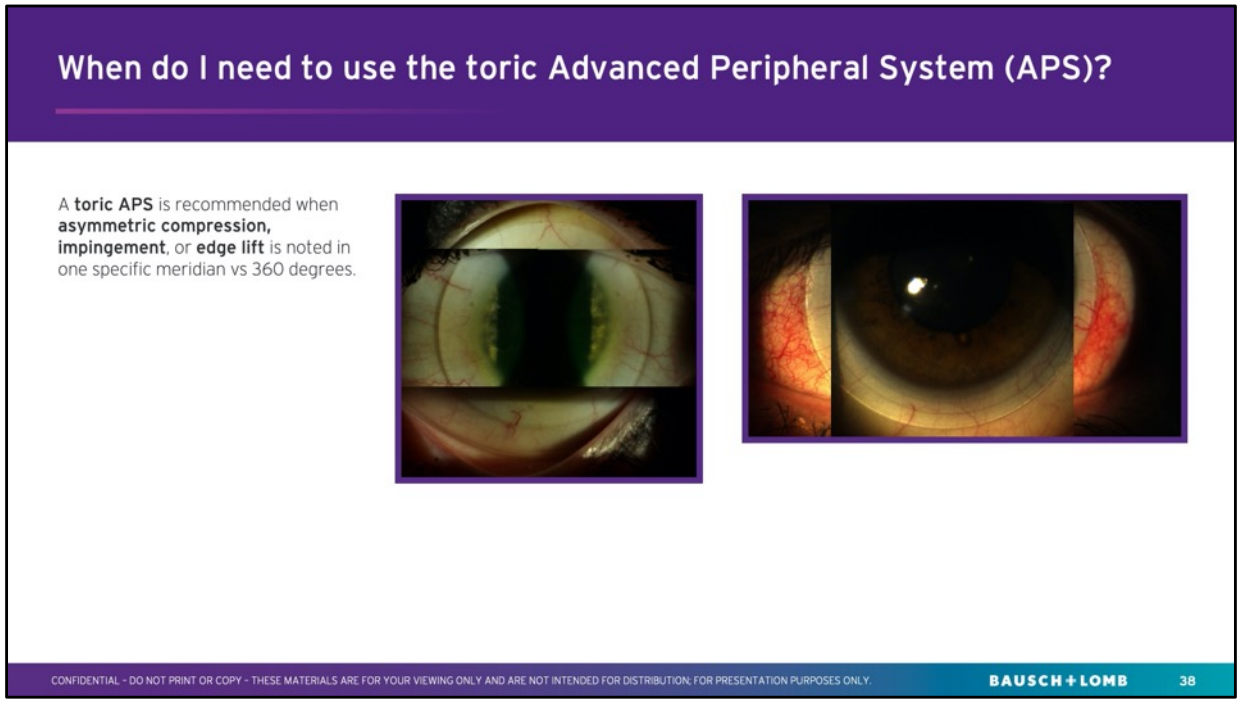
- Fluorescein can help to identify edge lift by visualizing tear pooling



Key Talking Points:

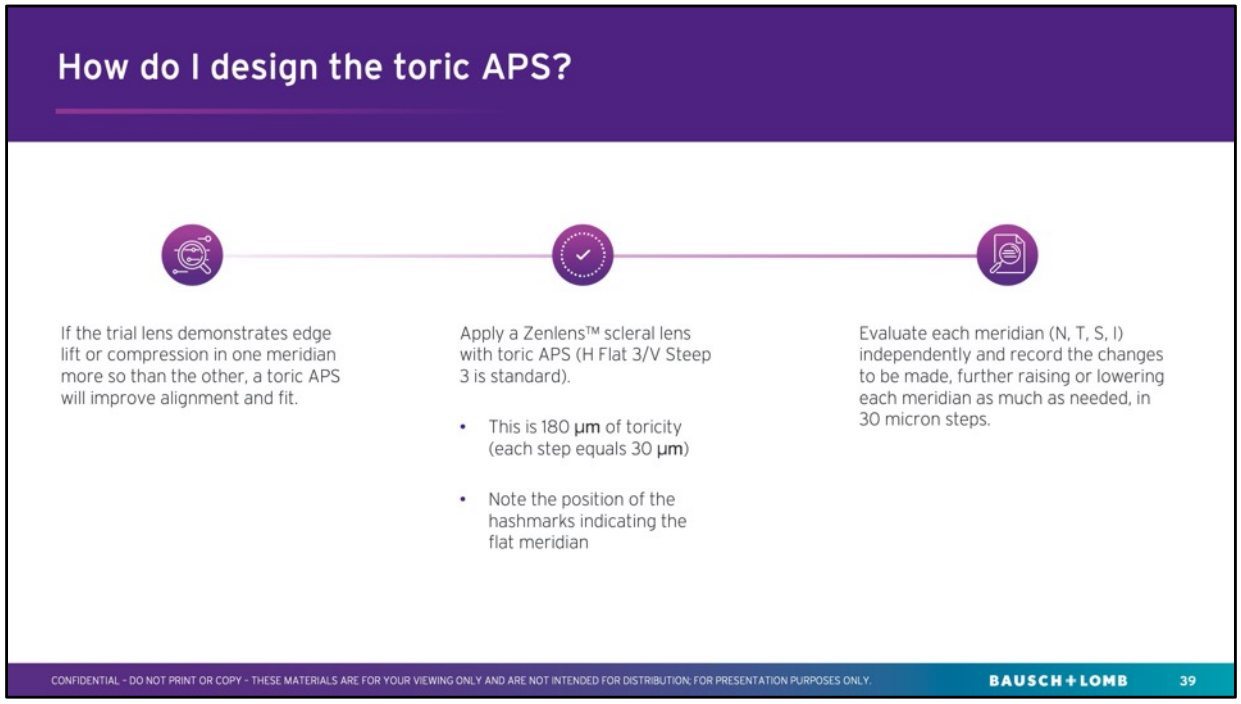
- The lens should be allowed to settle for 20 to 30 minutes in the office, if possible
- Poor visual quality may be due to debris on the lens, so it should be clean and wetted properly before performing over-refraction.
- Spherical over-refraction to best acuity should be done first, followed by sphero-cylinder over-refraction (SCOR) to see if front toric powers are required
- **Lens power** (front torics) should only be addressed **AFTER a good fit is achieved.**[1] **Note** that front toric power can be incorporated without a toric back surface


ADDRESSING AND REFINING
THE FIT



Key Talking Points:

- A toric Advanced Peripheral System (APS) is recommended when asymmetric compression, impingement, or edge lift is noted in one specific meridian vs 360 degrees. The practitioner will need to specify how many steps flatter or steeper is needed in one meridian vs the other
- Emphasize that flat or steep may occur at any meridian. Clearly identifying areas where “rocking” is occurring is important, as sometimes ECPs make changes to the horizontal meridian when the change needed to be made at the vertical meridian
- Toric Advanced Peripheral System (APS) is available to order—APS is a landing curve for fitting and does not provide toric optics
- If toric Rx is needed for vision, front toric optics can be added to the anterior optic zone
- Lenses with back toricity (toric peripheral curves [toric PC]) should be considered when the other diagnostic lenses do not fit well
- Toric PC lenses can be used as a guide to better understand how to adjust and customize the lenses
- Toric lenses are available to order in 30-micron steps and with flatter or steeper curves



Key Talking Points:

- N, T, S, I defined as N=Nasal, T=Temporal, S=Superior, I=Inferior

Assessing the toric APS

- Ensure that the dispensed patient appears in the doctor's office having worn the lens for at least 4 hours, if possible
- Remove the lenses yourself at the visit to assess degree of tightness
- Look for excessive fluorescein staining, especially over the limbus and conjunctiva
- Hold consultation with lab consultants if necessary

Speak to slide.

- The dispensed patient should appear in the doctor's office having worn the lens for at least 4 hours, if possible
- All meridians are not required to be perfectly tangent to the sclera
- Some tear exchange is desirable provided that it does not lead to visually impacting debris accumulation
- Always remove the lenses yourself at the visit to assess degree of tightness
- Look for excessive fluorescein staining, especially over the limbus and conjunctiva
- Presence of an impression ring after removal is indicative of poor alignment or inadequate landing zone surface area
- If only in one meridian, quadrant-specific APS may be indicated
- Consultation with lab consultants is always a good idea

Application of MicroVault™ technology to the APS

Zenlens™ scleral lenses with MicroVault™ technology are an innovation for dealing with pingueculae or other peripheral elevations that might otherwise interfere with a proper landing on the sclera

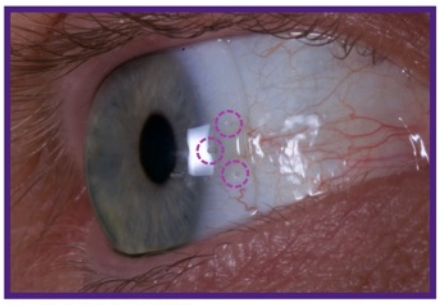
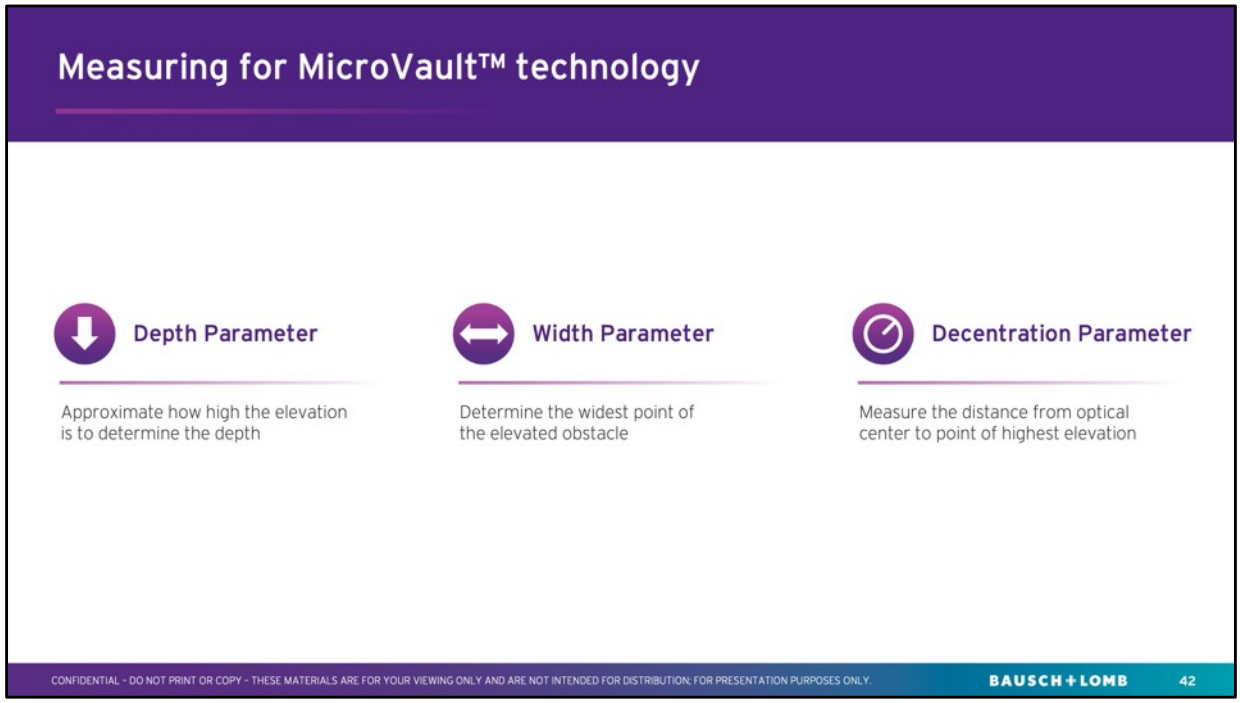


Image courtesy of Tom Arnold, OD, FSLS

- MicroVault™ technology creates a precisely designed flute or ripple in the edge of Zenlens™ to vault the lens up and over the peripheral obstruction
- MicroVault™ technology can be applied to any Zenlens™ design that has been stabilized with a toric APS or front prism ballast
- MicroVault™ technology can be specified inside of the lens (ie, not at the edge) if required

  Consultation can assist in these cases

Read slide



Key talking points:

Depth parameter
Approximate how high the elevation is to determine the depth. Keep in mind that 900 microns is the maximum depth.
Note: Depth can be precisely measured with an anterior segment OCT

Width parameter
Determine the widest point of the elevated obstacle. Using a slit-lamp reticle or the beam of the light, measure the maximum width desired

Decentration parameter
Measure the distance from optical center to point of highest elevation. If obstacle is at the lens edge, the highest elevation of the MicroVault™ technology is at the lens edge. If the obstacle is under the lens, measure the distance from the edge to the peak of the center of the elevated obstacle

Assess lens edge to identify location where debris may be entering postlens tear layer (PLTL)

Fluorescein placement on surface

Image courtesy of Jason Jedlicka, OD

Visual of NaFL seeping

Image courtesy of Jason Jedlicka, OD

To evaluate for excessive exchange due to edge lift, fluorescein can be painted on the front surface of the lens or on the superior conjunctiva and then watched to see where the tear exchange is occurring[1]

A steeper APS, either 360 degrees or meridian-specific (toric APS), would be necessary based on where the tear exchange is occurring[1]

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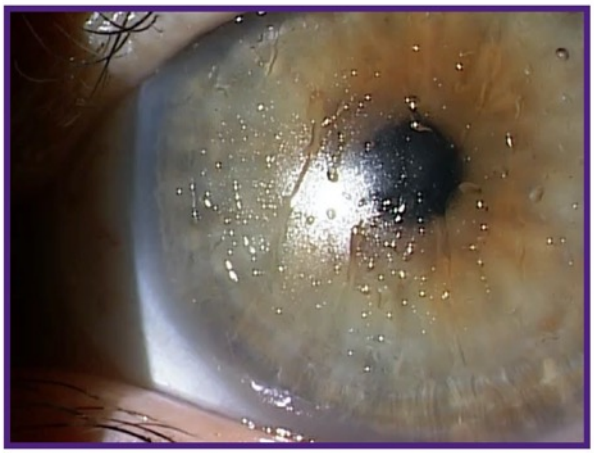
Key Talking Points:

- Fogging can be caused from excessive overvaulting centrally, if the landing zone is too steep or there is narrow surface contact, or from excessive exchange due to edge lift
- To evaluate for excessive exchange due to edge lift, fluorescein can be painted on the front surface of the lens or on the superior conjunctiva and then watched to see where the exchange is occurring
- A steeper APS would be necessary, either 360 degrees or meridian-specific (toric APS), based on where the exchange is occurring.
- Should inform ECP that a nonpreserved saline should be used
- Emphasize that ECP should stay in the chair after coating the lens with fluorescein and watch specifically for where it leaks behind the lens

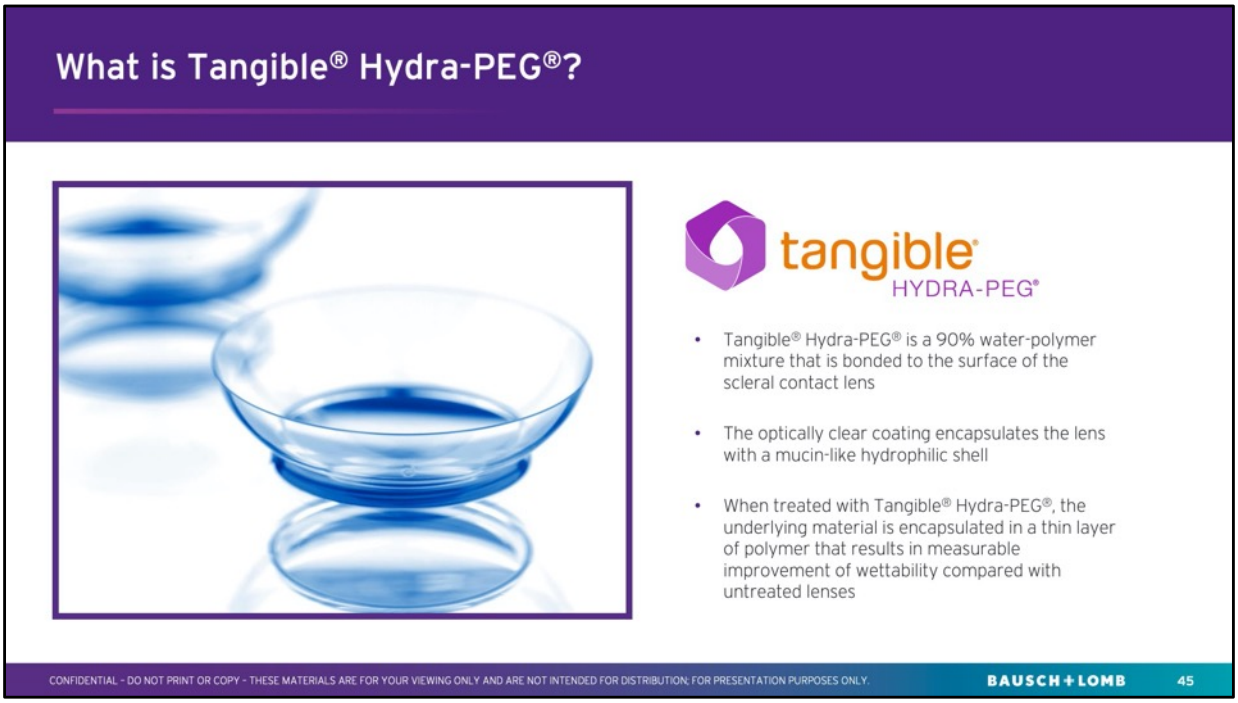
Surface wettability: Why is it important?

- Surface wettability plays an important role in lens comfort
- Wettability can affect lens deposition (debris accumulation can create fogging)
- Poor surface wettability can create unwanted movement of the lens



Key Talking Points:

- Contact lens wettability plays an important role in:
    - Contact lens comfort
    - Optimizing quality of vision
    - Maintaining a healthy tear film
- A poorly wettable surface can cause dry patches on the lens that may:
    - Increase the deposition of lipid and denatured protein from the tears (debris accumulation). Fogging is thought to be due to debris accumulation on the front surface of the lens
    - Cause the inner surface of the upper eyelid to temporarily stick to the dry portions, causing the lens to lift during a blink excursion
- The image shows scleral lens surface debris (optimum material)



Key Talking Points:

- Tangible® Hydra-PEG® is a 90% water-PEG-based-polymer mixture that is covalently bonded to the surface of the contact lens, effectively creating a wetting surface on the underlying lens material and separating it from the ocular surface and tear film. The optically clear coating encapsulates the core contact lens with a mucin-like hydrophilic shell
- When treated with Tangible® Hydra-PEG®, the underlying material is encapsulated in a thin layer of polymer that results in measurable improvement of wettability (sessile drop contact angle) compared with untreated lenses
- The coating technology and process is owned by Tangible® Science, and Bausch + Lomb (Alden Optical lab) will apply it to lenses under license from Tangible® Science
- A lens must be made with Tangible® Hydra-PEG®; it cannot be added to an existing lens

Boston XO® or Boston XO_2® materials for your scleral lenses

Boston® materials, coupled with a wide range of lens designs, provide a solid foundation for specialty lens practices. Boston® continually champions the gas permeable (GP) industry with its commitment to education, a wide range of GP materials, high Dk levels, and collaboration with laboratories.

Boston XO®

Boston XO® is a tough, stable, high-Dk material that can be made into a wide variety of special designs for demanding visual needs.

- Material Name: hexafocon A
- Oxygen Permeability (Dk): 100*

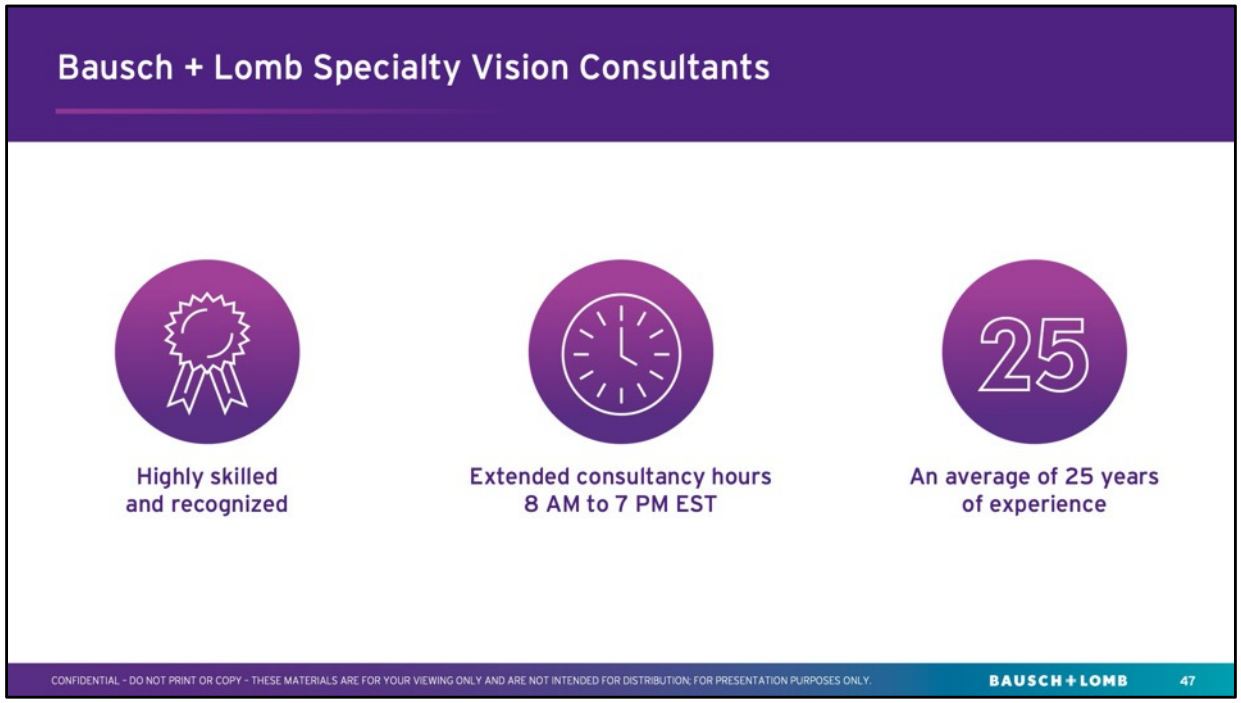
Boston XO_2®

Boston XO_2® has excellent oxygen transmissibility with the stability of a lower-Dk material.

- Material Name: hexafocon B
- Oxygen Permeability (Dk): 141*

*ISO/Fatt method.

Speak to slide



Key talking points:

- Vision consultants offer on-demand, individualized support and fitting solutions for even extremely challenging cases
- Experts in helping you achieve patient comfort and satisfaction

Safety information for eye care professionals

Important Safety Information for Gas Permeable and Customized Soft Contact Lenses

WARNINGS:

- Patients should be advised of the following warnings pertaining to contact lens wear:
  - Problems with contact lenses and lens care products could result in serious injury to the eye. It is essential that patients follow their eye care practitioner's directions and all labeling instructions for proper use of lenses and lens care products, including the lens case. Eye problems, including corneal ulcers, can develop rapidly and lead to loss of vision.
  - Daily wear lenses are not indicated for overnight wear, and patients should be instructed not to wear lenses while sleeping. Clinical studies have shown that the risk of serious adverse reactions is increased when daily wear lenses are worn overnight.
  - Studies have shown that contact lens wearers who are smokers have a higher incidence of adverse reactions than nonsmokers.
  - If a patient experiences eye discomfort, excessive tearing, vision changes, or redness of the eye, the patient should be instructed to immediately remove lenses and promptly contact his or her eye care practitioner.

Speak to slide

Safety information for eye care professionals (cont.)

CONTRAINDICATIONS:

- Do not use when any of the following conditions exist:
  - Acute or subacute inflammation or infection of the anterior chamber of the eye
  - Any eye disease, injury or abnormality, other than keratoconus, PMD, that affects the cornea, conjunctiva, or eyelids
  - Severe insufficiency of lacrimal secretion (dry eye)
  - Corneal hypoesthesia (reduced sensitivity), if not aphakic
  - Any systemic disease that may affect the eye or be exaggerated by wearing contact lenses
  - Allergic reactions of ocular surfaces or adnexa that may be induced or exaggerated by wearing contact lenses or using contact lens solutions
  - Allergy to any ingredient in a solution which is to be used to care for contact lenses
  - Any active corneal infection (bacterial, fungal, or viral)
  - Red or irritated eyes

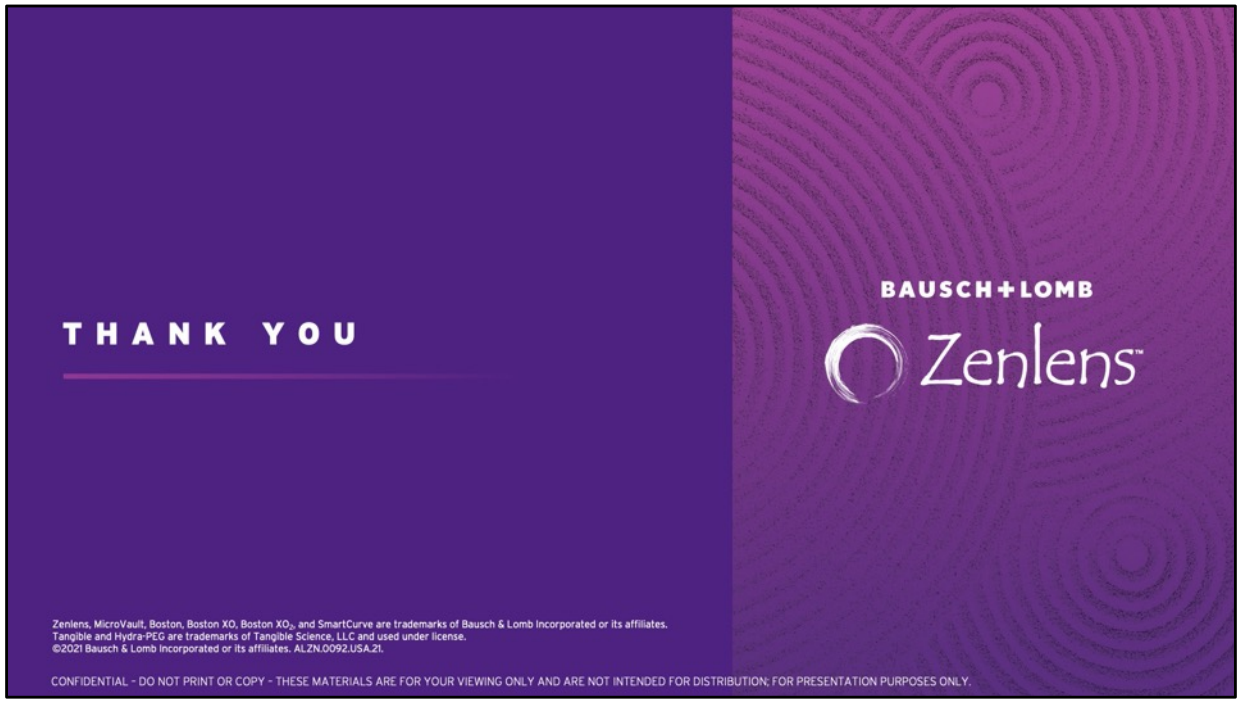
Speak to slide

Safety information for eye care professionals (cont.)

ADVERSE EFFECTS:

- The following problems may occur with the use of contact lenses:
  - Eyes stinging, burning, itching, irritation, or other eye pain
  - Comfort is less than when the lens was first placed on the eye
  - Feeling of something in the eye such as a foreign body, scratched area
  - Excessive watering (tearing) of the eye
  - Unusual eye secretions
  - Redness of the eyes
  - Reduced sharpness of vision (poor visual acuity)
  - Blurred vision, rainbows, or halos around objects
  - Sensitivity to light (photophobia)
  - Dry eyes

Speak to slide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