How I instituted the IDRA Dry Eye System into my Practice

by Robert Gerowitz OD, FIAO, FSLS

What was the great disconnect?

For many years I have worked to incorporate dry eye diagnosis and treatment into my practice. Like many doctors my definition of this significant eye health issue has continued to evolve from, "here's some eye drops" to "let's insert punctal plugs" to "you need to heat up the glands of your eyelids". Likewise, my diagnostic acumen had transitioned from tear break up time measurements and eyelid expression to MMP-9 testing.

The great disconnect from diagnosis to treatment has always lay between my knowing what the patient needs to do, to actually getting them to do it. Taking the advice of my friend and colleague, Dr. Thomas Weshefsky as well as listening to webinars by Drs. Art Epstein and Laura Perlman; I used the recent COVID downtime to restructure and re-invent my dry eye program.

The key to these changes was recognizing that clinical dry eye has three major commonalities:

1. Patients may not be overtly symptomatic due to long-standing adaptation to how their eyes feel; a form of corneal nerve anesthesia
2. Most cases of dry eye is due to Meibomian gland dysfunction
3. Ocular inflammation is a common contributor or sequelae of dry eye disease

With these three things in mind, I sought out a method to take what I had observed diagnostically and get patients to "buy into" treatment and thus improve their condition.

After investigating various methods to visually demonstrate to patients that their dry eye was more than just something drops could fix (indeed I actually tell patients that "if eye drops were all that was required to handle dry eye, I probably would never hear about it from my patients"). Ultimately, I settled on the IDRA Dry Eye System from SBM Sistemi of Italy.

What makes IDRA different from other devices that do more than just meibography?

Among this system's features are:

- **Dry Eye Questionnaire-5 (DEQ-5)**
- **Interferometry to determine lipid layer thickness**
- **Blink evaluation**
- **Non-Invasive tear break up time (NIBUT)**
- **Tear meniscus height**
- **Meibography**
- **Library of grading scales**

What are my Standard Operating Procedures (SOPs) for testing?

For all patients 21 and over, we start with the DEQ-5. For patients that have no symptoms or score 0 to 1 and do not report any dryness, burning, grittiness, or fluctuating vision during case history; we do not test further.

For that age group that scores 2-5, we test tear meniscus height, NIBUT and lower lid meibography OU.

And, for those that score 6 or above we do the full battery of testing listed above.

Lastly, as DED is also found in minors, we use the 2-5 and 6 or above scoring protocols for patients under the age of 21 who are symptomatic as assessed on case history.

How do I present the case to my patient?

Again, after listening to how others discuss diagnostic findings with their patients (Art Epstein uses a great analogy to the structure of a house) I realized that the IDRA tests tell a story. And, like every great story, I start with the introduction or in other words the results of the DEQ-5.

Next, I tell the patient Chapter 1 of their story or what most patients feel is the cause of their dry eye symptoms. With few exceptions, patients feel that the root cause is not enough tears. In fact, many have already gone out and purchased various artificial tears that provided either temporary or no relief; and certainly no amelioration to the etiology of their DED. With that in mind, we look at their tear meniscus. Often these are at an acceptable level of .2 to .5mm which means their tear quantity is also fair to good.

In Chapter 2, I relate interferometry to something they may have observed: oil floating on a puddle. We talk about the optical interference of colors and its overall depth. IDRA analyses this finding as a percentage and also as a visual red-yellow-green "speedometer" representation that is easy for the patient to understand.

In the next two chapters, I continue to discuss their story as relates full or partial blink and its importance to good ocular health and non-invasive tear break up time and how it relates to lipid layer depth (interferometry).

In the final chapter, we look at their meibography. To expedite testing, we commonly do just lower lid testing and evaluation, but with superior lid eversion the upper Meibomian glands can also be evaluated. The IDRA gives the practitioner four different gland views including a 3D version which can be spun on its own axis and again a percentage score and "speedometer" assessment.

With the patient fully engaged in their case, the last thing we present is the "Moral of the Story". While treatment methods may differ and there is no-one- size-fits-all way to approach dry eye, there are some commonalities for more routine (non-Sjogrens or those that don't involve neurotrophic keratopathy) instances of DED. It is during discussion of the Moral that we outline our Home Toolkit for Dry Eye Relief and in-office therapies.

What's the moral of this story?

IDRA has made dry eye diagnosis, case presentation and patient treatment acceptance infinitely easier. In the first three months of this year, we have started more dry eye patients on home and home/in-office therapies than the last three years!

Based on its lower cost compared to similar systems, smaller footprint, and ease of staff training, I would strongly suggest "test driving" the IDRA Dry Eye System in your office.

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