

Dry Eye in Optometry: When Are Drops No Longer Enough?

Optometrist perspectives on the move from passive symptom relief to mechanism-driven ocular surface care, and the clinical, financial, and workflow barriers shaping that transition.

Real Opinions • Peer Patterns • Validated by Data

35

total responses captured

22

complete responses

4

countries represented

62.9%

survey completion rate

WHY THIS REPORT

Dry eye care is becoming more medical, but the practice model is still catching up.

TFOS DEWS II frames dry eye as a multifactorial disease involving tear-film homeostasis, inflammation, ocular surface damage, and neurosensory factors. That clinical complexity has expanded the treatment toolkit, but it also creates a practical question for optometrists: when should a familiar home-care pathway become a structured medical service with diagnostics, procedures, and repeated follow-up?

This report interprets responses from practicing optometrists and eye care professionals across United States, Canada, Italy and France.

How to read this report. The survey captured 35 responses, including 22 complete and 13 partial responses. Country distribution was recorded across the United States, Canada, Italy, and France. Question bases vary because partial responses were included in earlier profile items; the main clinical questions use bases of 22 or 23. Percentages and response counts are reproduced from the source export. Options with no recorded responses are shown as 0.0% only where the displayed counts exhaust the full question base.

EXECUTIVE SUMMARY

Six findings that define the peer tension in this topic.

INSIGHT 01

The field is moving forward, but most practices remain in the middle

47.8% describe a therapeutic or prescription-led model, while only 26.1% identify as advanced procedural centers.

INSIGHT 02

Advanced procedures are usually a second step, not the starting point

52.2% move to procedures after treatment failure or compliance burnout, compared with 17.4% who present them immediately.

INSIGHT 03

Demodex has changed how optometrists look at the lid margin

86.4% report either universal screening or increased symptom-triggered inspection.

INSIGHT 04

Patient acceptance is primarily a financial conversation

59.1% cite immediate financial shock, well ahead of value skepticism or session burden.

INSIGHT 05

IPL is the leading technology in this cohort

59.1% identify IPL as delivering the fastest relief, followed by thermal gland expression at 31.8%.

INSIGHT 06

The business model has not fully integrated

77.3% say the dry eye clinic remains neutral or isolated from optical revenue.

PRACTICE MATURITY

01 Most optometrists have moved beyond basic care, but not into full procedural ownership

47.8%

describe a therapeutic or prescription-led model

CONTEXT

Dry eye management can range from reactive lubricant advice to a dedicated procedural service with diagnostics, repeated treatments, and longitudinal maintenance.

WHAT THE DATA SHOWS

The cohort divides evenly between advanced procedural centers and baseline or traditional care at 26.1% each, while 47.8% sit in the prescription-led middle.

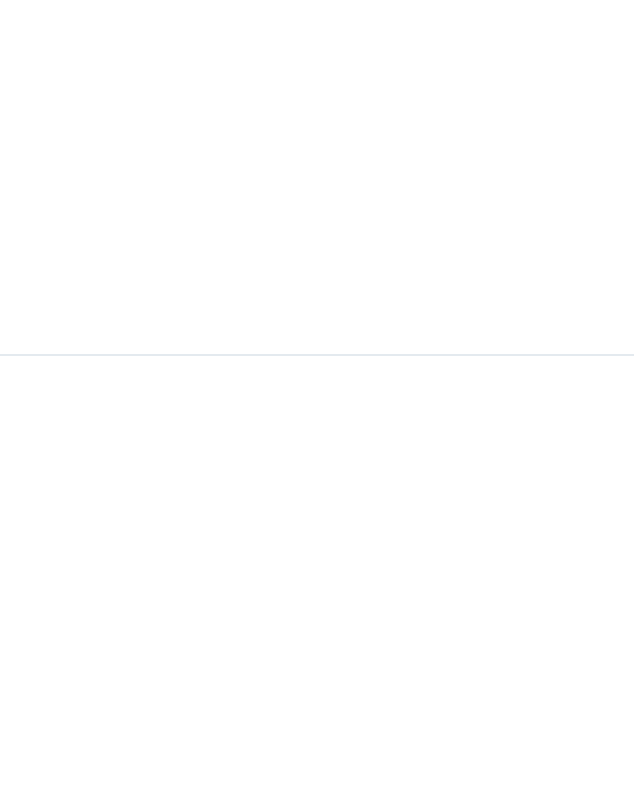
THE INSIGHT

The center of gravity has shifted away from purely passive care, but most practices have not yet reorganized around procedures.

WHY IT MATTERS

The opportunity is not only clinical adoption. It is designing the staff, schedule, diagnostic sequence, and patient communication needed to make the medical model sustainable.

Current dry eye practice model



ESCALATION THRESHOLD

02 Procedures are usually introduced after the home-care pathway has already strained

52.2%

use procedures as step-two therapy after failure or burnout

CONTEXT

Moving too early may feel financially aggressive; moving too late may allow persistent disease and patient frustration.

WHAT THE DATA SHOWS

52.2% transition after failure or compliance burnout, while 17.4% present procedures immediately, 17.4% reserve them for late-stage rescue, and 13.0% rarely recommend them because of constraints.

THE INSIGHT

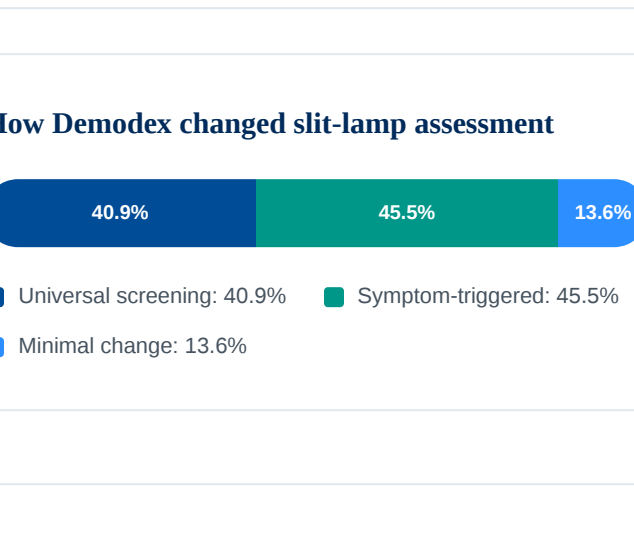
Most optometrists are using failure of the previous step as the trigger, rather than a pre-defined disease mechanism or risk threshold.

WHY IT MATTERS

A clearer transition rule can make escalation more consistent and easier to explain to patients.

When practices move beyond home therapy

Share of respondents



LID-MARGIN DIAGNOSIS

03 Demodex has entered the routine examination, but screening is not yet universal

86.4%

report a meaningful increase in Demodex-focused inspection

CONTEXT

FDA approval of lotilaner ophthalmic solution established a targeted treatment pathway for Demodex blepharitis, making recognition of collarettes more actionable.

WHAT THE DATA SHOWS

40.9% now use universal look-down screening, 45.5% inspect more closely when symptoms are present, and 13.6% report minimal change.

THE INSIGHT

Therapeutic availability appears to be changing diagnostic attention, but many practices still rely on symptom-triggered detection.

WHY IT MATTERS

A consistent lid-margin step may reduce missed Demodex disease in patients whose symptoms are labelled only as generic dry eye.

How Demodex changed slit-lamp assessment



DIAGNOSTICS AND ACCEPTANCE

04 Meibography supports the conversation, but rarely replaces traditional clinical evidence

81.8%

call imaging helpful but secondary

CONTEXT

Objective images can make gland change visible, but a high-cost image does not automatically prove treatment necessity or likely response.

WHAT THE DATA SHOWS

81.8% describe imaging as helpful but secondary, 13.6% call it mandatory, and 4.5% view it as unnecessary overhead.

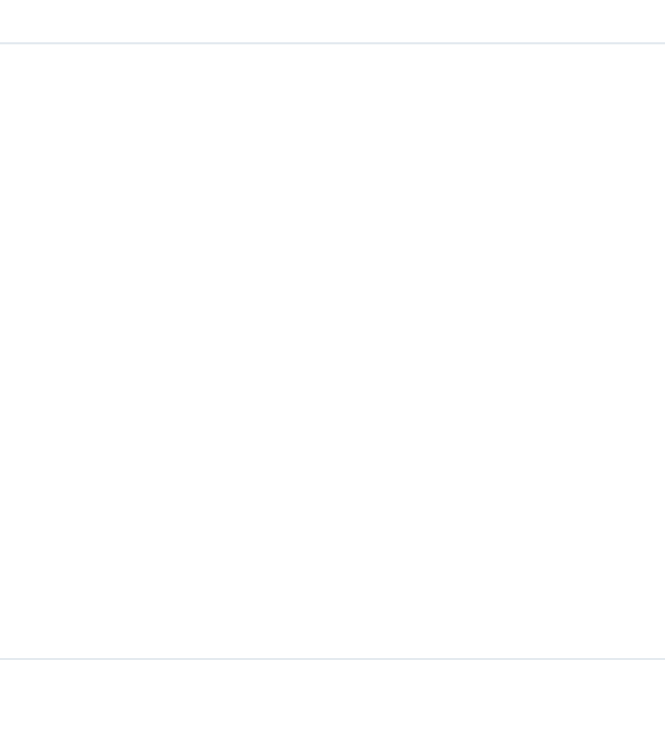
THE INSIGHT

The peer view is balanced: visualization adds value, but case acceptance remains grounded in symptoms, staining, tear-film findings, and clinician interpretation.

WHY IT MATTERS

Practices can use imaging to support shared understanding without turning it into a sales substitute for clinical reasoning.

Role of gland imaging in case acceptance



PATIENT ECONOMICS

05 The largest barrier is not belief in treatment. It is the first price conversation

59.1%

cite immediate financial shock

CONTEXT

Advanced procedures are frequently outside routine medical or vision coverage, creating a gap between clinical recommendation and patient expectation.

WHAT THE DATA SHOWS

Immediate financial shock leads at 59.1%, followed by value skepticism at 27.3%, session burden at 9.1%, and no major barrier at 4.5%.

THE INSIGHT

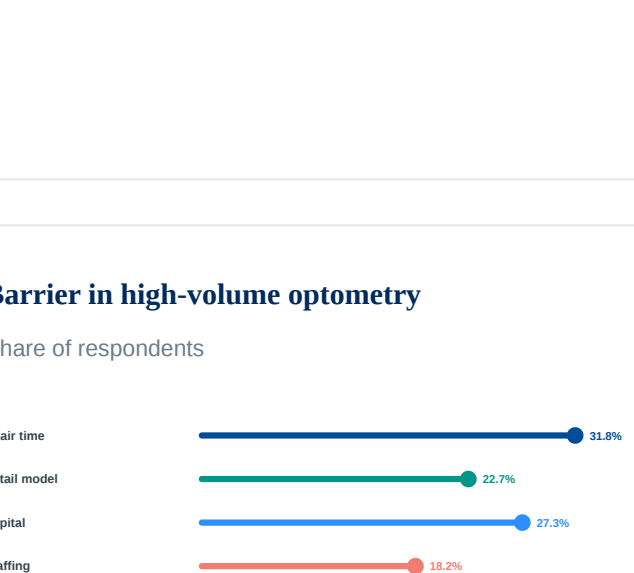
The acceptance problem begins before clinical efficacy is debated. Patients first need to understand why a procedure in an eye clinic may not be insured.

WHY IT MATTERS

Transparent fee discussions, expected treatment course, alternatives, and maintenance requirements should be part of the clinical pathway, not a late administrative add-on.

Primary barrier to advanced procedure acceptance

Share of respondents



TECHNOLOGY PREFERENCE

06 IPL leads, while thermal expression remains the main alternative

59.1%

identify IPL as delivering the fastest relief

CONTEXT

Different technologies address different components of evaporative dry eye and meibomian gland dysfunction.

WHAT THE DATA SHOWS

IPL leads at 59.1%, thermal gland expression follows at 31.8%, and RF and canaliculi fills each receive 4.5%.

THE INSIGHT

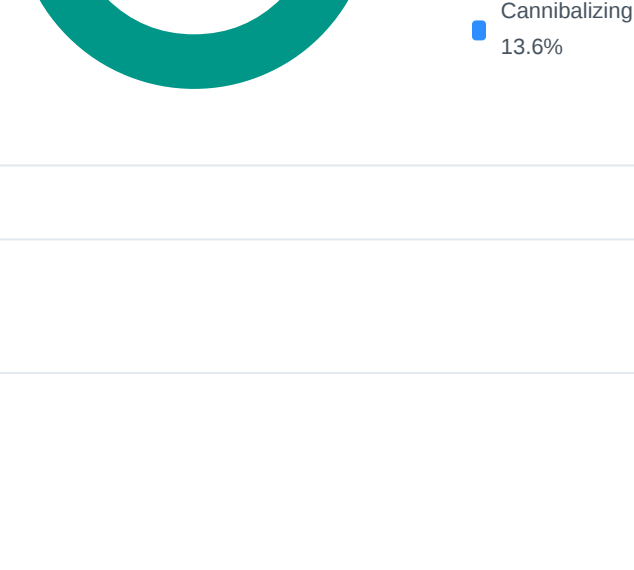
This cohort favors a technology positioned around inflammatory and vascular mechanisms, while still retaining a strong role for direct gland evacuation.

WHY IT MATTERS

Capital decisions should follow the practice's case mix, protocols, staffing, and follow-up capacity rather than technology popularity alone.

Technology associated with fastest relief

Share of respondents



MAINTENANCE BURDEN

07 Follow-up beats automation, yet almost one-third still see compliance as unresolved

40.9%

say rapid follow-up is the most effective compliance strategy

CONTEXT

Chronic dry eye care often falls between visits, when home routines compete with daily life and symptoms fluctuate.

WHAT THE DATA SHOWS

40.9% favor a strict rapid follow-up, 27.3% favor product bundling, 31.8% report no effective strategy, and automated reminders recorded no responses.

THE INSIGHT

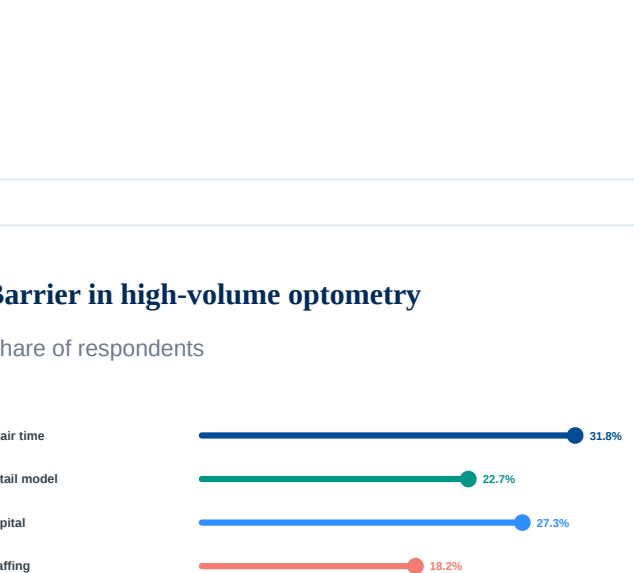
Accountability and reassessment appear more persuasive than digital nudges alone.

WHY IT MATTERS

Maintenance plans need a scheduled clinical checkpoint, not only a list of products or automated messages.

Most effective home-care compliance strategy

Share of respondents



PRACTICE DESIGN

08 The retail chair-time model is structurally misaligned with medical dry eye care

31.8%

name chair time as the largest corporate barrier

CONTEXT

Comprehensive ocular surface care requires history, testing, counseling, treatment planning, and follow-up that do not fit easily into rapid referral turnover.

WHAT THE DATA SHOWS

45.5% treat dry eye concurrently without delaying motivated patients seeking presbyopia drops. Separately, 77.3% report no measurable effect on optical revenue.

THE INSIGHT

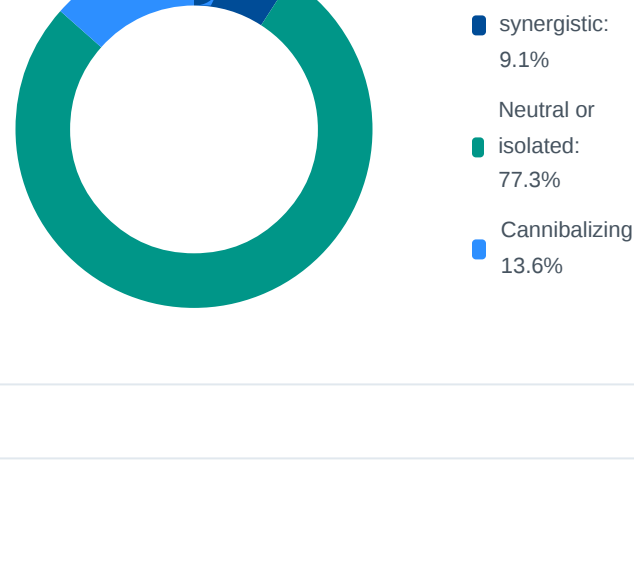
Clinical integration is advancing faster than business integration.

WHY IT MATTERS

Practices should evaluate dry eye services on their own clinical and financial metrics rather than assume automatic optical spillover.

Barrier in high-volume optometry

Share of respondents



ADJACENT SERVICES

09 Ocular surface care influences prescribing, but remains commercially separate

77.3%

see the dry eye clinic as a separate profit center

CONTEXT

Dry eye can affect visual quality, contact lens tolerance, and response to lifestyle drops, yet its commercial integration with optical services is uncertain.

WHAT THE DATA SHOWS

63.6% treat dry eye concurrently without delaying motivated patients seeking presbyopia drops. Separately, 77.3% report no measurable effect on optical revenue.

THE INSIGHT

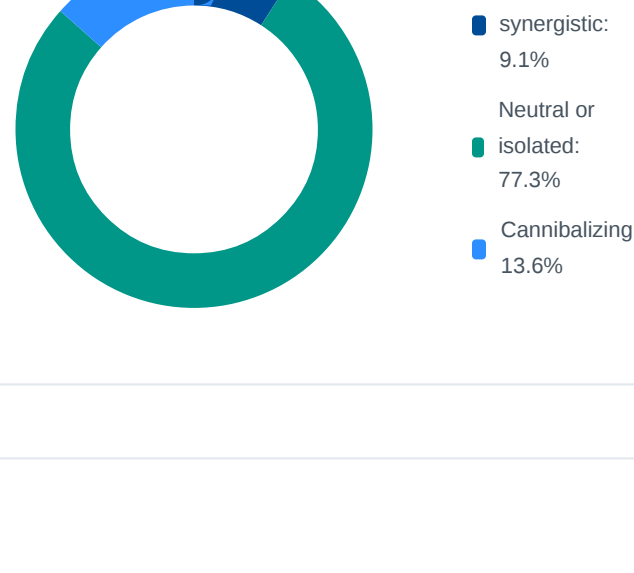
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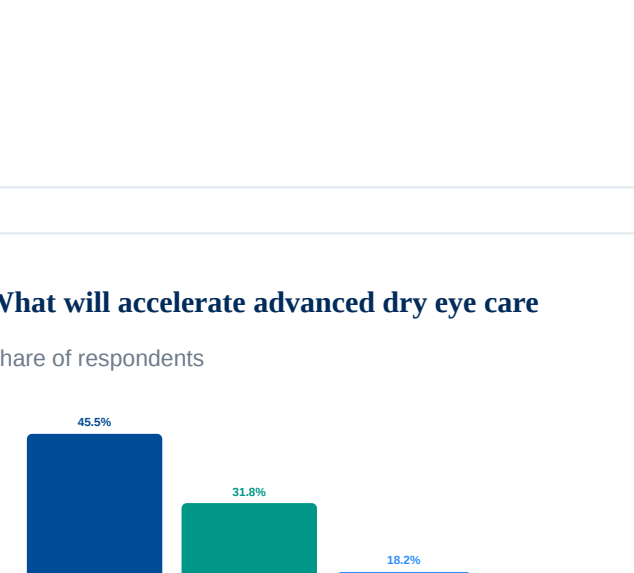
How dry eye affects presbyopia-drop selection

Share of respondents



Impact on optical dispensary revenue

Share of respondents



FUTURE ADOPTION

10 Reimbursement is the strongest lever, but lower-cost technology is close behind

45.5%

prioritize reliable procedure coverage

CONTEXT

Mainstream adoption depends on both patient affordability and practice access to equipment.

WHAT THE DATA SHOWS

45.5% choose reimbursement reform, 31.8% lower-cost portable platforms, 18.2% consumer awareness, and 4.5% expanded certification.

THE INSIGHT

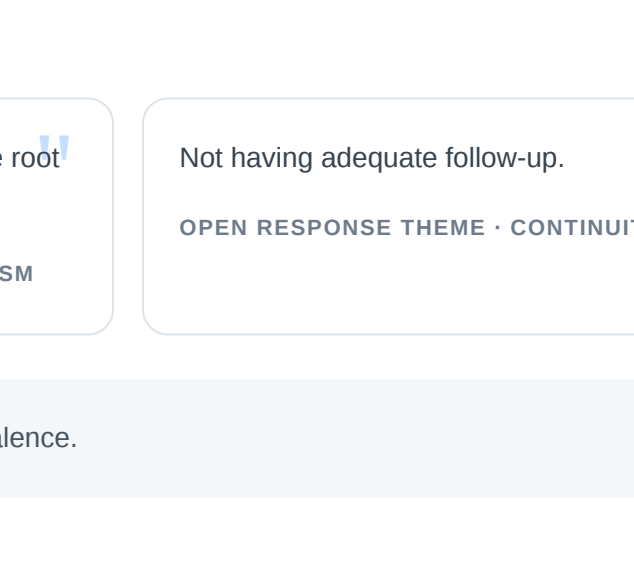
The market will not scale through education alone if the economics remain difficult for both patient and practice.

WHY IT MATTERS

Payers, vendors, and professional education must move together if advanced care is to leave a small number of specialized clinics.

What will accelerate advanced dry eye care

Share of respondents



OPEN RESPONSE LENS

What peers say the numbers cannot fully capture

The comments repeatedly return to one concern: passive treatment can miss the mechanism. Peers described under-testing, overlooking Demodex, continuing drops without reassessment, failing to refer when procedures are needed, and losing patients when improvement is too slow or poorly explained.

Only considering drops and not prescribing procedures like IPL

11

OPEN RESPONSE THEME • PASSIVE CARE

They do not test and do not treat the root cause.

OPEN RESPONSE THEME • MECHANISM

Not having adequate follow-up.

11

OPEN RESPONSE THEME • CONTINUITY

Interpretive note. Open-ended comments add context but are not quantified as prevalence.

PRACTICE LENSES

Four lenses for building a credible ocular surface pathway

The survey points to a model that combines clinical mechanism, patient communication, protected workflow, and realistic financial planning.

Diagnosis before escalation

Mechanism lens

Differentiate evaporative, inflammatory, lid-margin, and compliance-driven problems before layering therapies.

Transition criteria

Treatment lens

Define when persistent findings justify moving from home care to prescription or in-office intervention.

Patient understanding