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# Dry Eye and Contact Lens Wear: Improving Comfort, Retention, and Patient Satisfaction



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Join Drs. Koetting and Poteet as they review how optometrists can improve comfort, retention, and patient satisfaction in contact lens patients by treating dry eye.

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in Denver, to make the case that oftentimes [contact lens dropout](#) is a dry eye problem, not a contact lens problem.

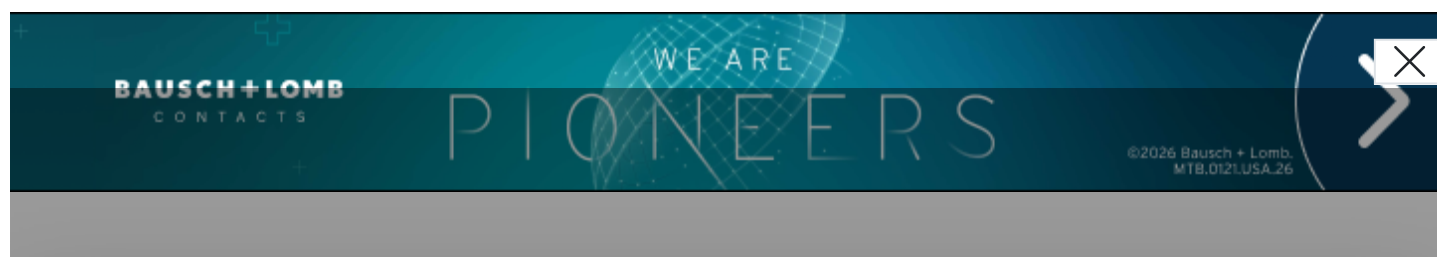
## Dry eye and contact lens dropout fast facts

- Contact lens discomfort is the leading cause of dropout, affecting an estimated **12 to 51%** of wearers; [dry eye disease](#) is the primary underlying driver.<sup>1</sup>
- [Evaporative dry eye](#), predominantly driven by [meibomian gland dysfunction \(MGD\)](#), accounts for **86%** or more of dry eye cases in clinic-based cohorts.<sup>2</sup>
- Screen-based tasks significantly reduce blink rate and increase incomplete blinks, accelerating tear film evaporation and MGD progression.<sup>3</sup>
- During screen tasks, the mean rate of incomplete blinks is **16.1%**, with a significant positive correlation between incomplete blink frequency and ocular symptom scores.<sup>3</sup>
- Switching contact lens brands or materials without treating the underlying ocular surface does not restore tear film stability. The lens is not the problem.

## Why contact lens dropout starts at the ocular surface

Dr. Poteet [fits contact lenses](#) daily across a high-volume primary care population; Dr. Koetting sees patients after they have already dropped out. By the time a patient drops out of contact lenses, most have already cycled through two or three brands. They were switched from lens to lens and nothing helped.

Nobody stained the cornea. Nobody looked at the meibomian glands. Dr. Poteet and Dr. Koetting have seen the same patient from opposite ends of that story, and their conclusion is the same: **until the ocular surface is stable, no lens will be comfortable.**



# MGD, digital devices, and the dropout cycle: why the lens swap never works

By the time most dropout patients reach an ocular surface specialist, they have already cycled through two or three lens brands, highlighting an opportunity for earlier evaluation of the corneal surface and meibomian glands.

MGD drives more than **86%** of dry eye cases, and when the lipid layer breaks down, the tear film evaporates too fast.<sup>2</sup> No [silicone hydrogel or water gradient material](#) fixes a poor functioning meibomian gland.

Screen use reduces blink rate to as low as **7 per minute** and drives a mean incomplete blink rate of **16.1%**—meaning the meibomian glands are not fully expressed with nearly one in six blinks.<sup>3</sup> For a contact lens patient on screens all day, incomplete blink-driven lipid layer thinning is not a risk factor—it is a daily clinical reality.

[Vital dye staining](#) and [meibomian gland evaluation](#) on every contact lens patient before fitting is the non-negotiable both doctors return to. If the anterior surface is lighting up, that eye cannot tolerate a lens comfortably. That finding reframes the entire visit—not which lens, but what is wrong with the surface.

When needed, Dr. Poteet gives patients [3 to 6 months of ocular surface treatment](#) before committing to a lens modality. That timeline is the minimum needed to re-establish a stable tear film the lens can actually tolerate. She explained, “I ask every patient not just ‘Do you see well?’ but ‘How comfortable are your eyes at the end of the day?’”

## Key takeaways

- [Contact lens dropout](#) is a dry eye problem. Switching lens brands without treating the ocular surface does not work.
- [Evaporative dry eye driven by MGD](#) accounts for 86% or more of dry eye cases.<sup>2</sup> Address the lids before reaching for a different lens.
- [Stain every contact lens patient before fitting](#). A staining cornea tells you the lens is not going on comfortably.
- [Screen-heavy patients](#) have reduced blink rates and a high rate of incomplete meibum expression every day. Counsel them before they become a dropout.



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- Treat the ocular surface first, then fit. Give it 3 to 6 months. The lens outcome depends entirely on what the surface can tolerate.



## Conclusion

Dr. Poteet had a patient who had worn glasses since age 6, was recently divorced, and had been told contacts were simply not an option. Three to 6 months of dry eye treatment later, she walked out of the exam room with her hand over her heart.

Watch the full conversation with Dr. Poteet and Dr. Koetting to see how they get patients like her back into lenses—and what treatment escalation, modality selection, and a systematic ocular surface approach actually look like in practice.

For more on diagnosing and managing dry eye in contact lens wearers, check out [The Dry Eye Workup in Contact Lens Patients](#).

This article was written by [Keren Beki](#) based on the recorded conversation between Drs. Koetting and Poteet.

## References

### About Cecelia Koetting, OD, FAAO, Dipl. ABO

Dr. Koetting is an Assistant Professor at the University of Colorado School of Medicine in the Department of Ophthalmology in Denver, CO. Her primary focus is in anterior segment and ocular surface disease, neuro-optometry, and peri-operative care. She partakes in clinical research and has served Externship Director and adjunct faculty for several schools and colleges of optometry.

### About Julie Poteet, OD, MS, CNS, FOWNS

Julie Poteet, OD, MS, CNS, FOWNS graduated from The New England College of Optometry and then completed a residency in primary care and ocular disease at the VA Medical System in Boston. At the VA, Dr. Poteet became interested in why some veterans seemed to age so differently than their peers and began questioning what lifestyle factors have the greatest impact on health and vitality....

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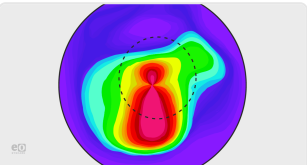
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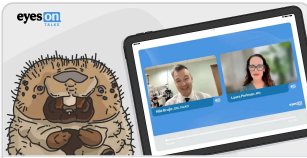
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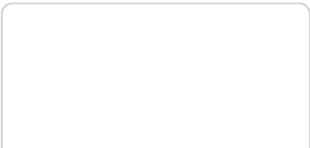
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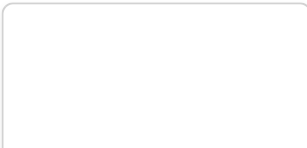
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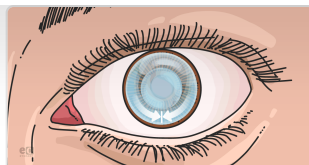


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