**Q: Can Blepharitis be hereditary and can it be brought on by hormonal changes?**

**A:** There can be an element of hereditary aspect to Dry Eye and hormonal changes do affect Dry Eye Disease (DED). DED is one of the forty-eight symptoms of perimenopause and menopause.

---

**Q: If we catch Blepharitis early enough, can we prevent DED in the future?**

**A:** Yes, once caught and diligently treated/managed evaporative DED can be avoided.

---

**Q: Can you use the hypochlorous spray indefinitely?**

**A:** Yes. Watch here for more information: Ros Mussa FBDO CLO introduces The Eye Doctor Hypochlorous Eyelid Spray

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**Q: How would you explain dry eye in the simplest way for the patient to understand the disease in the front of house?**

**A:** Great Question! It's when they eyes don't produce enough tears or they evaporate away too quickly, this means the eyes becomes dry, irritable, sore, red and painful, you can have one to all of the listed symptoms and this also means the vision can be disturbed too.

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Unit 1, Bridge Industrial Estate
Park Mill Way
Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

the-body-doctor.com

**Q: Do you not need to use lid wipes if you have hypochlorous spray or do you need both for Blepharitis?**

**A:** These are different products that work in different ways and give relief to different factors. Some patients will benefit from one or the other, and some benefit from using both.

---

**Q: Should spray or eyedrops be recommended for both Blepharitis and DED? Or is the spray better for Blepharitis?**

**A:** Hypochlorous spray is beneficial for both Blepharitis and DED. It helps the maintenance of homeostasis benefiting both conditions. There are different drops in the marketplace, with different constituents that benefit eyes in different ways. It is as much about the constituents and their effect as it is the form of application.

---

**Q: Would you recommend the hypochlorous spray over dry eye drops?**

**A:** It depends on the individual case.

Drops generally are there to reduce evaporation. There are other drops such as manuka honey drops that are way more sophisticated in their use.

The spray is a harmoniser that helps maintain bacterial load i.e. not allowing the bacterial load to get too high, it is a long-term acting product. The products work in different ways on different factors, so we should assess the full condition to understand the best treatment.

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E sales@the-body-doctor.com
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**Q: Why have Blepharitis treatments (wipes, lotions, etc) come to the market so late?**

**A:** Great question. There have been treatments available for decades – baby shampoo, 'artificial tears' etc, it is more recently that research has led to more products coming available. There will always be earlier adopters (patients and practitioners) of 'new' concepts and products, and as more people become more familiar with these demand increases and supply increases too. Also, all products brought to market have to undergo long detailed trialling and testing, and of course research and conclusions all take time too.

There is a rise in DED, it's known as the modern-day pandemic so more people suffer, more demand and therefore products can be mass made.

---

**Q: What degree does age have on the prevalence of Blepharitis?**

**A:** As we age and become more diseased the prevalence goes up.

---

**Q: Do we monitor and treat Blepharitis in young children the same as adults?**

**A:** Yes, we should.

---

**Q: Do you still advise tea tree products for Blepharitis? Do they have a positive impact?**

**A:** We do still use tea tree products.

---

**Q: Is there any oral medication for Blepharitis?**

**A:** IP guys will prescribe medication when Blepharitis gets really bad.

Unit 1, Bridge Industrial Estate
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Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

the-body-doctor.com

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**Q: What treatments would you recommend for patients who have MGD but not Blepharitis?**

**A:** Moisture emitting, antimicrobial heat eye masks, and hypochlorous spray and maybe drops. Think of these as the same condition, one is a precursor to the other.

---

**Q: How do you start up a dry eye clinic in practice? Can any DO run one?**

**A:** You need to be proficient and competent with slit lamp work as this is main instrument to fully investigate the anterior eye structures and homeostasis. A DO has to stay within scope of practice so cannot diagnose but can under instruction look at administering in house treatments.

A CLO and Optom can run Dry Eye clinics.

There is relevant training available supporting both front of house and the CLO's and Optom's – contact The Body Doctor for more details.

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**Q: If one was to run a dry eye clinic, what would you expect to charge for an appointment & what would be included in this appt? What would an approximate recall time be and would this be included in the initial appointment?**

**A:** Great question, and as with many of the services we as a profession provide there can be a wide range fees charged in the marketplace along with business consideration to be factored in.

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**Q: Should the drops recommended for DED always be preservative free?**

**A:** Ideally, yes.



Unit 1, Bridge Industrial Estate
Park Mill Way
Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

the-body-doctor.com

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**Q: What would you recommend for a patient who maybe takes eyedrops for another condition that may cause dry eyes?**

**A:** Great question. This patient will no doubt be being cared for by another medical or ophthalmological practitioner or consultant. Understanding the condition and the drops used, and maybe even reach out to the prescriber for clarity. And then look at a lubricating drop to aid comfort and maybe a spray to reduce the inflammation induced.

**---**

**Q: What do we look for in drops that helps with the lipid layer?**

**A:** Mineral oils and phospholipids.

**---**

**Q: In contact lens practice is it best to gauge tear prism height when the patient comes in wearing lenses, or later before fluorescein is instilled?**

**A:** You want to take all parameters into account when considering a holistic approach. You can assess the tear prism initially, and again after removal – knowing that removal will result in a change of tear film balance, as again will instilling fluorescein. You are trying to assess the 'patient's world' and the effect on their eyes by their environment this includes inserting and removing lenses, the time of day and environment this happens, and any signs we establish.

**---**

**Q: Is an eye compress more effective than drops?**

**A:** These are different products working in different ways on different areas of the eye and differing conditions. So, against MGD for instance a heat eye compress



Unit 1, Bridge Industrial Estate
Park Mill Way
Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

the-body-doctor.com

may be more effective, against demodex infestation an eye compress would be less effective.

---

**Q: Would you recommend using drops on every patient before their refraction? We have had quite a few re-checks recently where the rx wasn't too dissimilar from the original but px prefers that small change? Could this be down to Dry Eye?**

**A:** It could be down to dry eyes, and poor tear films, however there may be many other factors that could cause this, is the consulting room running very hot, or cold or strong air conditioning for instance. Is using an NCT is it being used correctly, or do you have a new operative who is taking more readings than others. Sometimes short form style testing rooms can give rise to small fluctuations. Applying a drop however will give the eyes the optimal environment and stabilise the ocular surface.

---

**Q: Should we recommend different eye drops for different seasons? Is there an eye drop you would recommend for dry eyes?**

**A**: Not really for different seasons, but maybe specific drops for specific tear disturbance. Some patients may exhibit specific tear disturbance at specific times which may require different drop/treatment/management. Fans or Air Conditioning in summer, or radiator, or heaters in winter, or Hayfever symptoms at specific times, these can all affect the homeostatic balance of the tears.

---

**Q: What's the best treatment for demodex?**

**A:** Lots of treatments available. Nulids or Zest away the biofilm and collarettes to start breaking that reproductive cycle. By removing the biofilm and collarettes the unhatched eggs are destroyed. Then look at products like Zocushield or Demex with



Unit 1, Bridge Industrial Estate
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Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

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the aid of some Hypochlorous to keep it home managed. You will need to repeat the NuLids/Zest treatments again to maintain.

Those who have IPL, Zest with IPL works well.

Helpful video's can be found on YouTube of me explaining Zest & NuLids:

Ros Mussa FBDO CLO performs a NuLids treatment in practice

Ros Mussa FBDO CLO performs a Zest treatment in practice

Ros Mussa FBDO CLO performs a Zest treatment on a patient in practice

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**Q: Where do demodex mites come from to begin with on a patient? Are they caught?**

**A:** They can be caught and transferred but do remember we all have them as we need them, we just do not need too many.

---

**Q: Is demodex the cause of Blepharitis?**

**A:** Blepharitis – lid inflammation, can be due to demodex

---

**Q: How easy is it to see demodex? I have never seen them.**

**A:** Down a slit lamp you can see signs of them, mag needs to be super high to actually see 'them'

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**Q: Can Zocushield be used as a home treatment?**

**A:** Yes



Unit 1, Bridge Industrial Estate
Park Mill Way
Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

the-body-doctor.com

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**Q: Are there any products that are child friendly?**

**A:** Most products are.

---

**Q: Are punctal plugs effective?**

**A:** Yes – for specific patients

---

**Q: Should punctal plugs go in top and bottom puncta?**

**A:** Mainly fitted at the bottom cos it's easier, but ideally both

---

**Q: Are the golf club spuds no longer used? or can it be used to remove Fb from cornea?**

**A:** They can still be used, but have been 'replaced' by newer, better proven, more effective less invasive treatments. Yes, can be used for FB removal.

---

**Q: There are lacrimal tablets available, do they help with disease?**

**A:** There are newer technologies and treatments for the Lacrimal system in DED. I do not recall a tablet to be taken orally purely for the lacrimal production and drainage system but oral products that negatively affect the quality of the aqueous produced and therefore trigger that disease cascade always should be at the forefront of our mind.

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**Q: What was the name of the mini mascaras please?**

**A:** Alot of companies do mini's i.e. Clinique. However, the Eyes Are The Story Product is the product I spoke about at the webinar.

**----------**

**Q: Is it better to dye lashes than use mascara?**

**A:** I cannot answer this as it does depend upon which dye, who is administering etc. I would say it's probably safer to use mascara from that variable aspect respect.

**----------**

**Q: What impact do glue false eyelashes have on tear film integrity?**

**A:** Cause inflammation at the base of the false lash which then sets off the cycle. Use hypochlorous daily to keep that inflammation down.

**ABDO** -The Tear Film & Ocular Surface Society published a lifestyle report in 2023 on the 'Impact of cosmetics on the ocular surface', which can be accessed here: https://www.tearfilm.org/ckfinder/userfiles/files/Cosmetics.pdf

**----------**

**Q: Ros was speaking about moisturiser. I understood that moisturiser too close to the ocular surface can induce breakdown of the tears film and increase problems associated with dry eye?**

**A:** Ah apologies for not being clear, no moisturiser near the eyes, drops containing HA act like a moisturiser.

**ABDO** -The Tear Film & Ocular Surface Society published a lifestyle report in 2023 on the 'Impact of cosmetics on the ocular surface', which can be accessed here: https://www.tearfilm.org/ckfinder/userfiles/files/Cosmetics.pdf

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**Q: Is it better and more hygienic to use a disposable eye bag than a reusable?**

**A:** So long as it's antibacterial and the instructions for use are followed, they are hygienically approved. The Eye Doctor Eye Compress has patented Sterileyes technology which acts as an antibacterial shield on the compress, clinically proven to reduce potentially harmful bacteria by up to 99.99%.

**----------**

**Q: I'm a DO on the shop floor. With so many products available, how do I know which best to recommend?**

**A:** It's a bit like which progressive lens would you choose for which patient, or which CL for which patient. We do our research, we build our experience, and we make recommendations based on our knowledge, research, and experience.

Things to consider are, what may be causing the DED (evaporative or MGD), what elements of the tears the drops affect (lipids, mucous etc), wetting agent, viscosity of drop, Ph, preservatives.

**----------**

**Q: Some patients come in after following the dry eye management plan discussed but don't feel a difference. I feel that they think I am trying to 'sell' eye drops and eyebags. How would you approach that?**

**A:** This is a great question and highlights the need for strong communication, and the Health Motivation Model we discussed. It's important to understand their world, and their motivations. It is also important to explain that we may be aware of signs, and the lack of symptoms for them is a good thing. For instance, if a patient takes medication for high blood pressure, when the blood pressure becomes 'normal' would you stop treatment? Or do we accept the treatment is maintaining the balance? Using simple terms helps patients understand the benefits of 'no symptoms and 'maintenance' so they remain motivated.



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Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

the-body-doctor.com

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**Q: Some of our px's do not always purchase recommended products. How could we advise them to take up the recommendation from the Optom?**

**A:** We are all good at 'reading' people, understanding their personality, their character etc. Link the benefits to them to their world, explain the impact of not taking the advice. Resistance is only an expression of a lack of understanding, value or the benefit. It may be how the Optom is making the recommendation.

---

**Q: I still hear a lot of Optom's recommended baby shampoo, any benefits as to why?**

**A:** This may be down to a lack of awareness of the more recent research and developments. This highlights the benefits of CPD etc. to avoid practitioners qualifying and never staying 'up to date' with new modern concepts and developments. It can be difficult, however, to encourage fellow team members to attend CPD sessions on DED might help them update their knowledge and advice for patients.

---

**Q: Our eye hospital still tells px's bicarbonate soda and baby shampoo and when we advise against this px think we're just trying to sell them stuff - how would you address this?**

**A:** This is a great question.

One route might be contact the hospital and offer them a training session, on modern treatments and management of DED. Also remember that hospitals never deal with maintenance, they deal with acute conditions and therefor do not progress in areas of management and maintenance. Also, cost for them at the NHS level is an issue so better recommend something (however poor) than nothing.



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HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

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Another route might be to explain to the patient that, excellent they are talking to you about management however, there are better/easier products to use, the products recommended are based on knowledge from 50s/60's, and the new products have been specifically developed for the eyes, with controlled ratios of constituents, controlled PH, specific chemicals/solutions for specifically targeting constituents of the tears. Maybe use an analogy like: Sun Cream… in the 60's we did not rate sun creams of lotions with an SPF, we did not have specially developed 'grades' of sun protection for our bodies, faces and scalp, we did not fully understand the benefits (and disadvantages of the sun and UV on our health.

Collective professional knowledge has progressed and developed, and it is our collective responsibility to upskill, improve our knowledge and of those colleagues around us, as well as to educate the public.

---

**Q: Regularly I see MGD GR2 or above but is symptomless and no corneal staining. How to convince a patient to manage this problem?**

**A:** If you are seeing this, you can take an image of this, and show this to the patient, maybe show them an image of a healthy eye, and maybe a worse eye, so you can show them what might happen if they do nothing, and how healthy their eye can be with good treatment and management. Ask the patient, would you rather we wait until you have symptoms, things are bad, and causing significant problems, discomfort, paid, redness etc, or give you advice to help prevent those symptoms, to create a healthy optimally functioning eye that is more resistant to disfunction? Maybe use the 'brushing teeth' analogy – we clean our teeth twice a day for 2 minutes a time to help maintain healthy teeth, gums, mouths etc…. we don't ignore them, wait for decay, have them removed, and replace with dentures.

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Unit 1, Bridge Industrial Estate
Park Mill Way
Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

the-body-doctor.com

**Q: I am suffering from a severe dry eye problem and Blepharitis and have been for more than a year. I am using Hycosan Extra, eye wipes and Optase moist heat mask. But I am not improving. I am waiting for an appointment at Moorfields for further treatment. In the meantime, could you kindly suggest any appropriate treatment please. I am on Amlodipine and Losartan for my mild blood pressure, I am 73 years old.**

**A:** It may be beneficial to visit Ros (me) in clinic who can and will assess what may be causing this and recommend appropriate treatment and management.

**----------**

**Q: Should it be a more gold standard part of the referral process to recommend a treatment plan, to create an optimal ocular surface, prior to surgery? This would reinforce our place in practice, as part of the multi-disciplinary team, supporting the patient journey.**

**A:** Assuming this relates to pre-operative cataract or Clear Lens Extraction and Intra-ocular lens surgery, then yes, we should be. It is a great opportunity to demonstrate our 'care' for our patients, and this will only have a positive impact on loyalty, trust and confidence resulting in greater referrals to us too.

**----------**

**Q: What tear break up time suggests dry eye?**

**A:** There is more to DED diagnosis than just TBUT – it is noted that to use TBUT as a measurement for diagnosis is also variable. One person counting to ten will be different to another person's perception of 10 seconds. This can also vary during the day, can be influenced by the time after instillation and the amount of fluorescein instilled. We should be looking at other factors and measurements too. That said it is widely accepted that a TBUT of 10 seconds or more is accepted as good. To diagnose, referring to DEWS, look at punctate staining more than the variability of TBUT.



Unit 1, Bridge Industrial Estate
Park Mill Way
Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
T +44 (0) 1484 868 816

the-body-doctor.com

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**Q: How likely are you likely to use Hycosan Shield in evaporative dry eye in conjunction with lipid based / moisturising or instead?**

**A:** The likely cause of Evaporative DED is poor lipid phase of the tears, and therefore a lipid-based drop would be a good first choice treatment option, but I tend to build in support for the other layers too as this is a dynamic condition. Do look at The Eye Doctor Advanced Triple Action Eye Drops, it is being well received. This is a good case study to see how they work at patient level: The Eye Doctor Advanced Triple Action Eye Drop - Patient Case Study

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**Q: Is there any link between coeliac disease and gluten exposure and dry eye as far as your aware?**

**A:** Many conditions have an impact on the endocrine system, creating chemical and/or hormonal imbalance in the body. This can of course give rise imbalance to the homeostatic status of the ocular surface and tears, so there may be a link.

---

**Q: If a px has rosacea, are they more prone to dry eye problems?**

**A:** Yes

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**Q: You mentioned a questionnaire - Where can I get a copy of this please?**

**A:** Assume this refers to a triage questionnaire, we have one at The Body Doctor that we can share based on DEQ5



Unit 1, Bridge Industrial Estate
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# Dry Eye Questionnaire

Name: .....

Date of birth: ...../...../..... Gender: .....

Please answer the following questions by circling the numbers in the box:

Questions about **EYE DISCOMFORT:**

During a typical day in the past month, **how often** did your eyes feel discomfort?

| NEVER | RARELY | SOMETIMES | FREQUENTLY | CONSTANTLY |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

b) When your eyes felt discomfort, **how intense was this feeling of discomfort** at the end of the day, within two hours of going to bed?

| NEVER HAVE IT | NOT AT ALL INTENSE | | | | VERY INTENSE |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

2. Questions about **EYE DRYNESS:**

During a typical day in the past month, **how often** did your eyes feel dry?

| NEVER | RARELY | SOMETIMES | FREQUENTLY | CONSTANTLY |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

b) When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

| NEVER HAVE IT | NOT AT ALL INTENSE | | | | VERY INTENSE |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 |

3. Questions about **WATERY EYES:**

During a typical day in the past month, **how often** did your eyes look or feel excessively watery?

| NEVER | RARELY | SOMETIMES | FREQUENTLY | CONSTANTLY |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

| Score: | 0 - 4 | 5 - 7 | 8+ |
|---|---|---|---|
| | you could be experiencing MILD dry eye. | you could be experiencing MODERATE dry eye. | you could be experiencing SEVERE dry eye. |

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Clayton West
Huddersfield
HD8 9XJ

E sales@the-body-doctor.com
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