

MiSight® 1 day - Live Webinar Q&A

What age does the child stop needing treatment?

Our current published research tracks children up to 15 years of age and the data shows that myopia is still progressing in both MiSight and single vision contact lenses. We continue to monitor these children and at this stage we would recommend that if the child is still happy with the vision from MiSight then they should remain in the lens.

Once a patient is wearing MiSight® 1 day, how many hours per day and how many days per week does a patient have to wear MiSight® 1 day for it to be effective?

In our study the children wore the lenses for a minimum of 6 days a week and 12 hours a day. There is some indication that from this study and other studies that longer wearing times drive greater efficacy.

What is the wearing schedule of MiSight® 1 day and what age is ideal to start?

Is the prescribed wearing time from the study of 6 days a week for 12 hours the recommended schedule for effective treatment?

In our study the children wore the lenses for a minimum of 6 days a week and 12 hours a day. There is some indication that from this study and other studies that longer wearing times drive greater efficacy.

In our study we started at age 8, though it does depend on each child and their own development and therefore capability to self manage contact lenses.

Would a longer wear schedule of the MiSight® 1 day make a difference?

During the study the children has to wear the lenses for a minimum of 6 hours a week and 10 hours a day so the variability in wear time is minimal but does indicate a higher efficacy with longer wearing times.

Is MiSight® 1 day going to be made available as a silicone hydrogel?

Other than the advantage of compatibility over Proclear® Multifocal, is there a reason why silicone hydrogel is not used for MiSight® 1 day?

We continue to develop the lens from both a material and design perspective but any changes require new validation of efficacy which takes a minimum of 3 years.

What is the Dk/t for MiSight® 1 day?

Dk/t for the MiSight 1 Day lens is 28 and the study showed no negative ocular physiology impact from wearing the lenses.

Being a somewhat lower Dk, should parents be encouraged to limit wearing time to 10 hrs/day and 6 days/week?

Dk/t for the MiSight 1 Day lens is 28 and the study showed no negative ocular physiology impact from wearing the lenses.

What are the differences between MiSight and Centre-Distance Multifocal?

MiSight has multiple treatment zones that align to the pupil of a child to ensure consistent treatment effect in all conditions. Traditional multifocal designs are optimised for the correction of vision and presbyopia in adults 40+ who have different pupil sizes and vision needs.

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How does MiSight® 1 day compare to a silicone hydrogel lens Biofinity® multifocal?

MiSight has multiple treatment zones that align to the pupil of a child to ensure consistent treatment effect in all conditions. Traditional multifocal designs are optimised for the correction of vision and presbyopia in adults 40+ who have different pupil sizes and vision needs. During the study the Proclear material was shown to have no negative impact on the corneal physiology.

What is the difference about the optics of MiSight® 1 day compared to the Proclear® Multifocal? Are there other differences? How does of MiSight® 1 day compare to a silicone hydrogel lens like?

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How do I choose which patients would benefit from MiSight® 1 day?

Our study shows that all children are likely to progress once they become myopic so all children are likely to benefit from the technology and sooner they start the more effective it will be. Both child and parent need to be fully engaged with the idea of wearing contact lenses and the wearing schedule.

What would the follow up schedule look like for a patient fitted with MiSight® 1 day?

Once the child is established in wearing and handling contact lenses then they can be managed as per other contact lens wearers in your practice.

Would the profile of the MiSight® 1 day lens, with its focusing ring structure, change corneal topography?

MiSight 1 Day is a soft hydrogel lens so it has no impact on corneal topography.

Do the treatment zones affect the quality of distance vision? Should we expect 20/20?

No, our study showed vision was equal both subjectively and objectively throughout the 3 years.

Why was +2 dioptre treatment zone chosen for MiSight® 1 day?

The lens was designed with a +2D treatment effect as the visual disturbance was found to be significant with higher treatment powers.

At initial fit for MiSight® 1 day, are we aiming to get 20/20 distance and 20/20 near? Or just go with SERE and then leave them in that prescription to trial until 1 week follow up?

We would recommend that you finalise the actual prescription in your normal way.

When treating with MiSight® 1 day, does the patient need to stay corrected to within 0.5D of their actual distance prescription to maintain efficacy?

When fitting of MiSight® 1 day, do you correct your patients in all visits close to 20/20?

We would recommend that you finalise the actual prescription in your normal way.

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If a patient is not 20/20 with MiSight® 1 day (despite being 20/20 with their prescription through glasses), do you recommend over refracting?

Yes, the normal approach would be to over-refract in this instance to optimise the contact lens prescription as per a normal spherical lens.

What is the definition of “high myopia?”

High myopia is generally as -5.00D or worse.

In terms of the relative risks, what are the incidence of retinal detachment and myopic maculopathy in an emmetropic patient?

The relative risk of an emmetropic eye is defined as 1 and this is the benchmark for the relative risk of myopes.

Do you recommend axial length measurement for patients that are undergoing a myopia control treatment? Or is measuring their refraction good enough to know if they are progressing?

In the ideal world we recommend measuring axial length as this is ultimately the driver of the risk. However, our study has shown that the change in refractive error and axial length is highly correlated which means that you can be confident that refractive error change is a good guide to the axial length change.

Does pupil size make a difference when using MiSight® 1 day?

Do the MiSight® 1 day study results take into consideration the patient’s pupil size?

In our study, we have seen no link between pupil size and efficacy.

Pupil size was measured and analysed. It was not seen to be a factor in efficacy.

How much myopia is enough to warrant fitting MiSight® 1 day? lenses? How soon can parents expect to see results?

The sooner the child is started the better as early intervention provides greater efficacy. Individual results vary as children progress at different rates, however, our data shows that on average progression is reduced by around -0.25D a year. The results from being spectacle free are observed almost instantly.

In terms of checking for efficacy, do you recommend using an autorefractor as an objective measurement and compare to the previous year’s rate of progression to determine if the treatment is effective?

We recommend cycloplegic refraction if possible at baseline and annually to verify the progression. Each year the progression should reduce due to the child ageing and the treatment effect based on the wearing regime that they follow.

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Is MiSight® 1 day only effective for patients between the ages of 8 and 12 years old?

Have there been any studies done on patients greater than 12 years of age?

Is the use of MiSight® 1 day recommended for patients younger than 7 years of age?

Our study enrolled the children between 8 and 12 for 3 years so it has already shown the lens is effective from age 8 to 15 and we continue to monitor the children for up to 10 years.

In our study we started at age 8 though it does depend on each child and their own development and therefore capability to self manage contact lenses.

All progressing myopia has been attributed to axial length changes so therefore we have no reason to believe that the lens will not be effective on older wearers who are progressing. A clinical study is being conducted on this.

Would MiSight® 1 day be effective for myopia control in older patients? For example, university-aged students or patients in their 20's who continue to increase in myopia.

Do you recommend that an older teen continue wearing MiSight® 1 day into their 20's? If not, at what age would you transition a patient from MiSight® 1 day to a single vision contact lens?

All progressing myopia has been attributed to axial length changes so therefore we have no reason to believe that the lens will not be effective on older wearers who are progressing. A clinical study is being conducted on this.

As children age their visual needs will change so as long as they can accept the optical effect of the lens then we would suggest continuing to treat while they are still progressing regardless of age. If their prescription has been stable for 3 years then switching to a single vision lens with initial 3 monthly monitoring is worth considering.

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Is there a maximum age after which treatment with MiSight® 1 day is not expected to have a positive effect?

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In the MiSight® 1 day studies, was it 1% tropicamide used, not cyclopentolate?

1% tropicamide was used as this is available at all sites.

As MiSight® 1 day is a therapeutic lens, would you anticipate that it would not be available for direct purchase by patients (online, etc.)?

MiSight® 1 day will only be available through approved Eye Care Professionals. Additionally, as this is a device designed for children it can not be supplied non-direct.



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Is there a maximum level of myopia that you would not consider using MiSight® 1 day for treatment?

At this stage, MiSight® 1 day has a power range up to -6.00. We encourage Eye Care professionals to initiate treatment as early as possible. As the product grows we will extend the power range, but hope through early intervention we can decrease the needs for stronger minus powers.

Have studies started showing a reduction in retinal detachment with the use of this MiSight® 1 day?

No this has not been shown and this will take many years and many wearers to be able to show an impact.

How does MiSight® 1 day compare to myopia control with orthokeratology (ortho-K)?

There are no comparative studies between MiSight®1 day and orthokeratology (Ortho-K).

Generally, it has been reported that Ortho-K provides around a 40% reduction in myopia progression, whereas MiSight® 1 day provides a 59% reduction in myopia progression.

If available, can you please address any data on the addition of atropine 0.01% to contact lens wear?

Does the addition of atropine increase treatment efficacy with MiSight® 1 day?

There is no data available on this.

Is there any data on the comparative efficacy of treatment with Atropine vs. MiSight® 1 day?

There are no comparative studies between MiSight® 1 day and Atropine.

How is axial length measured in the MiSight® 1 day studies?

This is measured using the IOL master with multiple measurements taken to ensure accuracy.

Is there a reduction in contrast or best corrected visual acuity (BCVA) while wearing MiSight® 1 day due to the treatment zone?

No, our study showed vision was equal both subjectively and objectively throughout the 3 years.

How does myopia progressing differ between contact lens vs. spectacle lens wear?

Our analysis has shown that the single vision contact lens progressed over the 3 years at a similar rate as previously published numbers for single vision spectacles.

Is the MiSight® 1 day data from one study only, and is the study ongoing?

The study is one study but using four sites around the world and the children are now all wearing MiSight 1 Day lenses for efficacy reasons and being monitored for a total of 10 years.

For how many years did/will the patients of the MiSight® 1 day wear the lens?

We are planning to continue the study for 10 years to monitor them until they are between 18 and 22 years old.

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What are the recommendations in fitting MiSight® 1 day for patients with a prescription outside of the study's range? (e.g., only -0.50 or over -4.00)?

Can patients with a prescription greater than -4.00 expect a similar outcome?

The MiSight lens is available between -0.25D and -6.00D and enrolment was between -0.50D and -4.00D for the purpose of the study to ensure that the wearers did not drop out due to their prescription progressing too far.

We are aware of practitioners using over-glasses where needed for higher prescriptions or astigmatism. We are not aware of the results that these provide.

How will MiSight® 1 day lens wear affect eyeglass prescription?

The reduction in progression from MiSight 1 Day lenses will directly affect the prescription in glasses. It is likely that they will need to change their glasses prescription less regularly.

What is the fitting procedure for MiSight® 1 day?

Please refer to the fitting guide for MiSight® 1 day.

What is the central diameter without defocusing, and the diameter for defocusing?

The diameter of the treatment zones are optimised for the pupil size of children but we do not publish this information.

With regards to ghosting, is there any concern with visual development considering the length of time the child will be wearing the MiSight® 1 day lens and their age?

Most children's eyes are developed by age 8 so this was not seen as an issue in the study. For the fitting of younger children, we would recommend closer monitoring.

Are there any concerns in doing a monocular treatment causing amblyopia in the treated eye?

Most children's eyes are developed by age 8 so this was not seen as an issue in the study. For the fitting of younger children, we would recommend closer monitoring.

How often should the patient be dilated over the course of treatment with MiSight® 1 day?

We recommend cycloplegic refraction and full ocular examination at the start and on an annual basis.

In patients with more than 1D of cylinder, should we lean towards controlling myopia vs. optimizing visual acuity in trying to reduce myopic progression?

With high cylinders there may be a need for over-glasses as well to provide acceptable visual correction. Ultimately the visual acuity is critical to ensure that the child can undertake their normal daily activities and compliance with the treatment regime.

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How much cylinder would be acceptable, and not reduce the treatment efficacy of MiSight® 1 day?

In the study we recruited up to -0.75D cylinder at the corneal plane and saw no impact on efficacy due to cylinder.

Though we have not studied it we are aware of practitioners using over-glasses for higher levels of astigmatism.

If the patient has significant astigmatism, is it possible to use glasses with the astigmatism correction in conjunction with MiSight® 1 day?

With high cylinders there may be a need for over-glasses as well to provide acceptable visual correction. Ultimately the visual acuity is critical to ensure that the child can undertake their normal daily activities and compliance with the treatment regime

What is the maximum amount of astigmatism this lens was used to treat during the MiSight® 1 day study?

During the study we started with a maximum cylinder of -0.75D. However, by the end of the three years the highest cylinder was -1.87D using the MiSight lens

Will there be future studies that will look at the use of MiSight® 1 day for the treatment of adult onset myopia?

There is a study underway looking at adult onset myopia.

What are the guidelines for prescribing MiSight® 1 day, in terms of patient age, current prescription, and whether or not the patient has astigmatism?

Please refer to the fitting guide.

Is there an ideal age to start wearing this lens? Or an ideal Rx?

Overall early intervention drives efficacy and the treatment should be started regardless of the age of onset of myopia.

Are there insertion and removal training materials for MiSight® 1 day developed specifically for the pediatric population?

More MiSight® 1 day patient materials will be available in the future

Are there MiSight® 1 day brochures for parents?

Yes, there are patient brochures for in-office.

Will there be toric versions of MiSight® 1 day in the near future?

Nothing is planned in the near future though use of over-glasses has been used by some practitioners to overcome this.

Was MiSight® 1 day made with a higher myopia range in Asian countries?

The prescription range is the same in all countries.

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What does SERE stand for?

SERE is Spherical Equivalent Refractive Error which is a combined measure of the sphere and cylinder of an eye to provide the average power of the eye.

Is there a quantitative number that we can quote to parents for the expected myopia control using MiSight® 1 day?

From our study we see around -0.25D a year reduction on average.

Is cycloplegic mandatory criterion for the initial prescription of MiSight® 1 day? Then, how often does the refraction require cycloplegic?

We recommend cycloplegic refraction at the start and on an annual basis.

If the patient's prescription is -0.75 and stable for a few years do you still suggest treatment with MiSight® 1 day?

In our study, we did see regression of myopia in some children so even those with a stable prescription may benefit from the treatment.

Have you ever fitted MiSight® 1 day on a patient with a prescription of -0.25?

In our study, the children initially has prescriptions from -0.75D to -4.00D but some children did regress to -0.25D during the study. Currently we do sell -0.25D in all markets and it is typically used when the other eye has already progressed further.

How often do you need to reassess and refit MiSight® 1 day?

We recommend a six-monthly follow-up once the child is fully adapted. An initial three month visit should be considered as slight regression is typically seen with any myopia management treatment in the first few months.

If you "over-minus" a patient using MiSight® 1 day, do you anticipate negating the effects of defocus and hence myopia control?

There is no evidence from the study that over-minus reduces the efficacy. We would recommend fitting the lens as per a normal sphere lens.

When the patients from the MiSight® 1 day were out of contact lenses and back into glasses, were regular spectacle lenses used? Are there any benefits to have them using progressive addition lenses (PAL) or MyoVision™ lenses?

During the study the children were wearing the lenses for long hours each day and over half wore the lenses 7 days a week. During their non-wearing times they would just use standard single vision spectacles.

We have no data on whether the use of other types of ophthalmic lenses would increase the efficacy of the treatment.

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What is the protocol if a patient is fitted with MiSight® 1 day and their myopia continues progress rapidly? Do we assume that their progression would have been higher without treatment?

Based on the study we have no indication that children did not respond to the treatment but we do know that they rate of progression varies significantly though again the reasons are unclear. Based on our assessment of the data in different ways we see a consistent reduction of around -0.25D a year between comparable groups.

Have you personally found patients preferring more minus in over-refraction with the MiSight® 1 day lenses compared with spherical lenses?

Our experience is that the expected prescription is the same as for a spherical lens.

Is there a recommended spectacle prescription that children should use during treatment with MiSight® 1 day when they are not wearing the contact lenses?

No we don't at this stage

What is the suggested price of MiSight® 1 day for patients?

CooperVision does not set pricing for any of our Customers. It is up to each ECP to decide what the appropriate pricing is for their market and for comparable products.

When will MiSight® 1 day be available in Canada?

When can we start ordering MiSight® 1 day?

You will be able to order MiSight® 1 day within a week of completing and passing the quiz.