

The Real Burden of Glaucoma Drops: What Patients Actually Experience



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After years of treating glaucoma, I've learned the hardest part isn't always lowering pressure. Instead, it's understanding what the daily burden of eye drops actually does to a person's life. The real breakthroughs happen when you truly listen to your patients and show them there's a better way.

When I completed my training in 2019, the default approach for glaucoma was still drops-first for the majority of patients. Around that same time, the LiGHT trial results were emerging and becoming a frequent topic of conversation. It can take years for new evidence to fully shift practice patterns, but the data on SLT as a first-line option kept gaining traction.

The field has advanced, and we now have stronger evidence and better technology than ever to treat glaucoma and help reduce the drop burden. Many

of us live and breathe this new information, but our patients often don't. This puts us in a unique situation: We have more tools than ever, but we have to guide patients towards the treatment choice that benefits them the most.

This is the crux of the matter: I much prefer a scenario where the burden of disease control falls on the doctor, not the patient. With modern interventional glaucoma treatments, the doctor taking charge is increasingly beneficial.

Some patients are more receptive to this than others, but I've learned that the key is to offer a clear, confident recommendation based on strong conviction in the treatment. The first step is believing in the option you're presenting. Once you have that conviction, guiding the conversation becomes much more effective.

Differing Patient Types

Glaucoma patients tend to fall into recognizable groups. Some openly admit they're struggling, whether with dry eye, irritation, or forgetting doses. Those conversations move forward fairly easily. Others insist they're doing fine, even when the clinical picture suggests otherwise.

Patients that are treatment naive come in without preconceptions and are often open to learning about all their options. In these cases, a confident surgeon recommendation is all they need.

The most challenging cases are the ones referred by a doctor they trust, and have often been on drops for years. Their pressures may be at target, the disease may feel asymptomatic, and they report being reasonably adherent—at least as much as they'll admit. They've grown used to the routine and may say, "I don't mind the drops," despite visual fields showing disease progression. These conversations require the most chair time.

I've learned to frame the intervention discussion respectfully. I always acknowledge that patients who've been receiving care have received good care, and that drops have been the historical standard. I tell patients directly, "I'd much rather have the burden of controlling your disease in my hands as your doctor than leave it entirely in yours. We know patients who stay only on drops don't do as well long-term compared to those who get doctor-administered treatment."

What Patients Tell Me When Starting the Conversation

When we first discuss interventional glaucoma therapy, patients' concerns are human and practical. They worry about risk. As soon as they hear "laser" or "drug implant" the questions come: Does it hurt? Is it dangerous? Aren't drops safer?

I explain that drops themselves aren't risk-free. Over time they can cause toxicity to the surface of the eye and create other problems like periorbital fat atrophy. Doctors know this—but it can be brand new information for some patients.

Other common questions include, "What if we use up our options too early?" This is an excellent question. I explain to patients to think of the opposite: If we let it get worse on drops first, then we're playing catch up and it's harder to treat down the road. So, it's better to intervene early whenever possible. Plus, we have lots of tools in our belt.

Patients are often concerned about the cost of interventional procedures. I always offer insurance estimates so there aren't any surprise bills. Many patients are surprised to learn that, in the long run, interventional procedures can actually be less expensive than ongoing drops.

In my experience, the younger a patient is, the more likely they'll want to do their own research and come in armed with knowledge. My response? Great! I have plenty of information ready for them in the form of handouts and actively encourage questions. If your recommendation is well-grounded, having a knowledgeable patient only makes the process easier.

When discussing drops versus intervention, I often explain things this way: "Your disease isn't symptomatic right now. If I give you drops that create symptoms, the burden of treatment becomes worse than the burden of the disease. We can keep the treatment asymptomatic as well." That often goes over quite well.

The Daily Reality of Drops

For some patients—and their families—keeping up with daily drops can feel like a part-time job. The mental load of remembering when to take them, coordinating refills, managing them around travel, work, and so on adds up.

The data is all there: 90% or more of patients did not refill their topical medications continuously over a period of 3 years, and approximately 50% of patients stopped taking their prescribed medications within 6 months.¹ A similar 30-70% struggle with ocular surface disease². But going beyond the data to specific cases really illustrates the effects of interventional glaucoma treatments.

One story that stands out is an elderly patient in her late 80s with mild dementia and only one good eye. Her family was with her in the room, and everyone was initially wondering why we were discussing changing her usual regimen of drops. Her IOP was ok on that day. She said she usually got the drops in. But when we dug deeper, her husband expressed some skepticism that she always got the drop in her eye. Her children chimed in with similar questions and doubts.

I explained my concern to them. "It makes me nervous that we're making it completely up to you to control your disease in your one good eye," I said. That seemed to turn the tide. If we can layer in something that adds control that's on me as a doctor, that makes me feel way better.

We started with a biodegradable implant right there in the clinic, and will soon move to a procedural pharmaceutical as the next step. It was nice to see the 180-degree shift in attitude in the room once we started asking some probing questions.

Families matter a lot in these cases. When somebody's getting help with drops from a family member, even one fewer medication can make a significant difference in quality of life.

Another patient who weighs on my mind is a 24-year-old man with mild open-angle glaucoma on an expensive medication (Vyzulta™). He has a strong family history of glaucoma and high untreated pressures. Because he's so young, I worry about decades of potential non-adherence. You know what it's like when you're young: you feel invincible and have so much going on that forgetting your meds is just natural. Furthermore, costs can add up, leading to serious lifetime expenses.

For patients like him, a sustained drug implant or iStent technologies offers a far more reliable long-term option. The psychology of intervening in someone so young is complex. Like any normal person, he was worried about needles in his eyes, but with so much life ahead I'd much rather pull the trigger and intervene early rather than leave him open to disease progression.

Adherence Confessions

It's a common story: Patients often start the visit by saying they're adherent to their drop regimen. As the conversation continues and they get more comfortable, however, the cracks appear. They

admit they don't always take drops on time one way or another. Common tells include not remembering the color of the bottle cap, saying "I've got it written down at home," or saying they're "almost out" or "down to bubbles."

I've heard all kinds of storage stories, which can go up to nightmare territory. One patient told me they kept their drops in the cheese drawer of the refrigerator, and I couldn't get the image of moldy cheese next to eye drops out of my head. Patients leave their drops in hot cars, forget them during travel, leave them in work desks, and otherwise find creative ways to misplace them.

This isn't any sort of indictment. We're all human and forgetting things is completely relatable. I myself use drops for dry eye, and even I forget to take them sometimes.

Side Effects and the Emotional Toll

We know the drops themselves aren't risk-free. The most common issues I hear aren't dramatic, systemic effects but persistent daily ones: fluctuating vision (which patients may not connect to drops), itchy red eyes, burning on instillation, or meibomian gland disease. Patients on multiple drops often come in exhausted from ocular surface disease.

As glaucoma doctors, we don't often get to be heroes; we don't get to reverse glaucoma damage. However, we can sometimes reverse ocular surface disease, which definitely makes us a bit of a hero in the patient's eyes (no pun intended). I sometimes treat one eye first just so patients can see and feel the difference in redness and comfort.

Being consistently on drops creates a slow emotional burn. Nobody likes to feel unhealthy, and drops are a constant reminder that a patient isn't entirely well. Interventional options provide real relief from all that psychological weight.

Life After Transitioning to Intervention

A very common regimen I see is dorzolamide-timolol plus another agent. This can mean three different drugs from two bottles, three times a day. Patients deal with all the ocular surface issues described above. But when we combine a drug implant with SLT or an iStent, many are able to stop drops entirely or reduce them dramatically within six weeks.

The happiness when they return on zero or one medication is profound. They're relieved to go back to their primary eye doctor with simpler follow-up.

I use iStent technologies frequently, often combined with cataract surgery because of its high safety profile and minimal impact on recovery. MIGS make me feel better about offering multifocal lenses to cataract patients with glaucoma, as their field of vision can suffer if left untreated.

A Message Patients Should Hear

Thanks to amazing data and fantastic new technology, it's now often best for both patients and doctors to let intervention help control the disease. We didn't always have these options, but now we do. The practice is moving forward, times are changing, and it's actually fun to practice glaucoma. Intervening earlier makes everything easier and more effective.

Listening carefully to patients' experiences over the years has completely changed how I approach every treatment conversation. Whereas before we were just managing pressure, we now can reduce the real daily burden and give patients back control over their lives. And hey, it sure feels good to get to be somebody's hero.

References:1: Nordstrom BL, Friedman DS, Mozaffari E, Quigley HA, Walker AM. Persistence and adherence with topical glaucoma therapy. *Am J Ophthalmol*. 2005 Oct;140(4):598-606. doi: 10.1016/j.ajo.2005.04.051. PMID: 16226511.

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