MDForLives

THE GLOBAL PULSE OF HEALTHCARE · OPHTHALMOLOGY INSIGHT REPORT

Glaucoma Eye-Drop Adherence: When Is It Time to Move Beyond Drops?

Responses from ophthalmologists on long-term glaucoma eye-drop adherence: how ocular-surface disease and dosing burden affect persistence, what signals suggest non-adherence rather than medication failure, why SLT is moving earlier, and where sustained-release therapy may reduce dependence on daily drops.

Adherence signal → Barrier → Treatment redesign → Sustainable IOP control

69	6	71%	8977449
Survey records	Countries represented USA · UK · Canada · Italy · France · Germany	Completion rate	Survey ID

WHY THIS REPORT

Glaucoma treatment can look inadequate when the real problem is that the regimen is too difficult to sustain.

Long-term IOP control often depends on a patient repeating the same eye-drop routine for years. Yet the disease may be asymptomatic, the medication may irritate the ocular surface, the dosing schedule may grow more complex, and accurate instillation may become difficult because of dexterity, cognition, vision, or simple treatment fatigue.

For the ophthalmologist, those barriers create a practical diagnostic problem. Fluctuating or elevated IOP can mean insufficient pharmacologic effect, inconsistent use, poor technique, refill gaps, or progression despite treatment. The next step changes depending on which explanation is most likely.

The MDForLives survey examines how ophthalmologists recognize that difference, what drives long-term non-adherence, how they respond when drops become difficult, where SLT sits in the current pathway, which patients prompt consideration of sustained-release delivery, and what may reduce drop dependence over the next 3–5 years.

> **Survey frame:** 69 survey records with a 71% completion rate across the USA, UK, Canada, Italy, France, and Germany. Question-level response totals vary. Internal operational, required-text, after-question, and honeypot fields were excluded from the analysis.

CLINICAL CONTEXT

Adherence, ocular-surface health, and treatment burden are becoming part of the glaucoma treatment decision itself.

Current guidance increasingly reflects a move away from treating adherence as an afterthought. NICE recommends 360° selective laser trabeculoplasty as initial treatment for selected newly diagnosed ocular hypertension at risk and non-advanced chronic open-angle glaucoma, and it specifically advises clinicians to ask about adherence and check instillation technique when IOP remains inadequately controlled on topical therapy.

The American Academy of Ophthalmology's 2024 technology assessment found strong evidence supporting the long-term effectiveness of SLT as primary or supplemental treatment for open-angle glaucoma. In the six-year LiGHT trial, 69.8% of eyes initially treated with SLT remained at or below target IOP without medical or surgical treatment, and the SLT-first arm showed better long-term disease control than the drops-first arm.

The topical side of the pathway is changing as well. A 2024 systematic review found that chronic benzalkonium-chloride-containing glaucoma therapy can contribute to ocular-surface disease and that preservative-free or less cytotoxic formulations can improve surface outcomes. Sustained-release options are also expanding: in the United States, the FDA approved the travoprost intracameral implant iDose TR in 2023 for reducing elevated IOP in open-angle glaucoma or ocular hypertension. These developments do not create one universal algorithm, but they broaden the choices available when daily drop burden becomes clinically important.

EXECUTIVE SUMMARY

Six findings that show why glaucoma adherence is increasingly a treatment-design problem.

01

38.6% estimate 26–50% of patients have adherence difficulty

Long-term eye-drop adherence is common enough to influence routine interpretation of unstable IOP.

02

36.8% identify ocular surface disease as the leading driver

Surface discomfort is the most selected reason patients struggle to stay on chronic topical treatment.

03

45.6% use pressure discordance as the strongest adherence clue

IOP that behaves differently across routine and unplanned checks raises concern that use may be inconsistent.

04

40.4% first simplify the topical regimen

Once-daily dosing or a fixed-dose combination narrowly leads moving toward SLT as the first adjustment.

05

40.0% use SLT first-line, with another 40.0% using it early when problems appear

SLT is already positioned before or early in adherence and tolerability difficulties for most respondents.

06

46.3% expect earlier SLT to reduce future drop dependence

The leading 3–5 year direction is a treatment-timing change rather than another topical formulation.

01

LONG-TERM ADHERENCE

Eye-drop adherence difficulty is common enough to influence routine glaucoma planning

38.6% estimate that 26–50% of their glaucoma patients have meaningful difficulty maintaining long-term eye-drop adherence; another 24.6% place the proportion above 50%.

CONTEXT

Glaucoma often requires years of pressure-lowering treatment, but the patient may feel little immediate difference between a day when the drops are taken and a day when they are missed. The treatment therefore depends on sustained behavior long after the urgency of the diagnosis has faded. For the ophthalmologist, the challenge is that adherence is usually inferred rather than directly observed.

WHAT THE DATA SHOWS

The largest response group, 38.6%, estimates that 26–50% of their glaucoma patients experience meaningful long-term adherence difficulty. A further 24.6% select more than 50%, 33.3% select 10–25%, and only 3.5% place the problem below 10%. These are clinician estimates rather than patient-level adherence measurements, but they show how frequently adherence enters the treatment conversation.

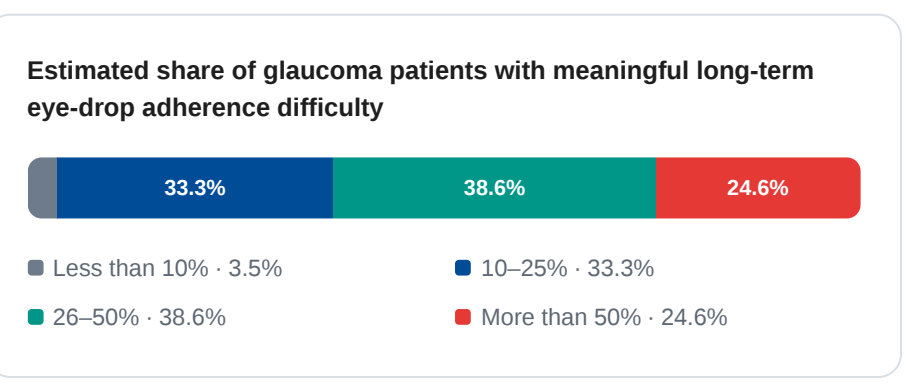
THE INSIGHT

The important signal is not a single population estimate. It is that many ophthalmologists expect adherence difficulty to be present often enough that an unstable IOP cannot automatically be interpreted as inadequate drug efficacy. The possibility of missed doses, inconsistent administration, or treatment fatigue needs to sit inside the differential whenever control is unexpectedly variable.

WHY IT MATTERS

If adherence is assessed only after several medications have failed, the patient may accumulate complexity before the original problem is understood. Earlier recognition creates room to simplify dosing, address tolerability, observe instillation technique, review refill patterns, or discuss a non-drop option before pressure instability becomes progression.

Estimated share of glaucoma patients with meaningful long-term eye-drop adherence difficulty



02

WHY ADHERENCE BREAKS DOWN

Ocular surface disease is the leading single driver of long-term non-adherence

36.8% identify ocular surface disease, including burning, hyperemia, or chronic discomfort, as the primary driver of long-term eye-drop non-adherence.

CONTEXT

An adherence problem that begins with discomfort is clinically different from one that begins with cost, dexterity, or an increasingly complicated dosing schedule. Chronic topical therapy can make these barriers accumulate: a patient may have surface irritation, multiple bottles, a schedule that is hard to remember, and little subjective sense of benefit from continuing treatment.

WHAT THE DATA SHOWS

Ocular surface disease leads at 36.8%. Regimen complexity and asymptomatic disease, limited perceived benefit, or treatment fatigue each account for 17.5%. Physical administration challenges account for 14.0%, and cost, insurance copays, or pharmacy refill barriers also account for 14.0%. No single explanation covers every patient, but surface burden is the most selected starting point.

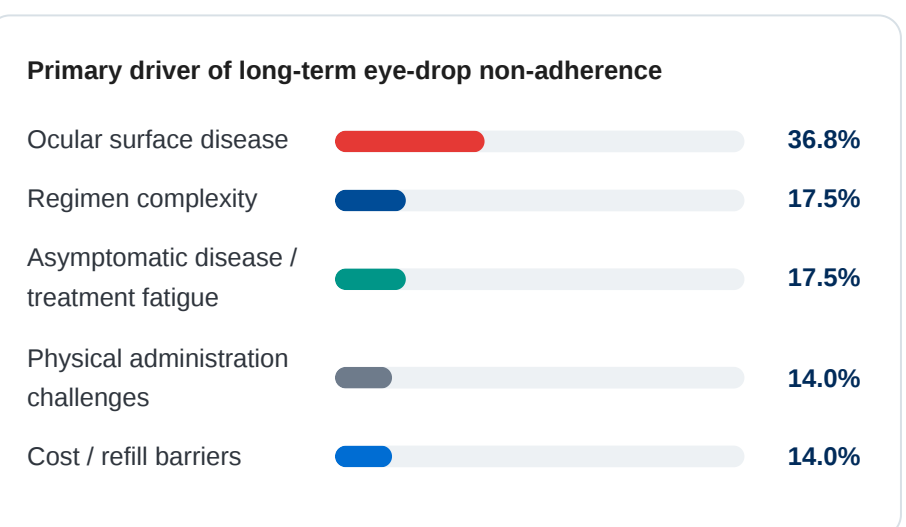
THE INSIGHT

The hierarchy argues against a one-size-fits-all adherence intervention. If discomfort is driving missed treatment, additional reminders will not remove the discomfort. If tremor or arthritis makes accurate instillation difficult, changing the message may not change the mechanics. If the regimen itself is the barrier, reducing the number of daily actions may be more meaningful than adding another educational touchpoint.

WHY IT MATTERS

Ocular-surface symptoms can also blur the distinction between efficacy and usability. A medication can lower IOP in principle and still fail in practice if the patient cannot tolerate it consistently. That makes surface health, dosing burden, and adherence part of the efficacy pathway, not separate quality-of-life issues.

Primary driver of long-term eye-drop non-adherence



03

RECOGNIZING NON-ADHERENCE

Pressure discordance is the strongest clue that the regimen may not be reaching the patient consistently

45.6% select a significant IOP discrepancy between routine visits and unplanned re-checks as the strongest indicator of non-adherence rather than medication failure.

CONTEXT

A clinic IOP is a snapshot. When pressure measurements do not fit the expected pattern, the ophthalmologist has to decide whether the drug is insufficient, the disease is progressing, the patient is taking treatment inconsistently, or the measurement itself reflects normal variability. That judgment often comes before any definitive evidence of adherence is available.

WHAT THE DATA SHOWS

IOP discrepancy between routine visits and unplanned re-checks leads at 45.6%. Pharmacy or prescription refill history showing delayed renewals follows at 24.6%. Stable visual fields or OCT despite fluctuating clinic IOP and ocular-surface findings suggesting intermittent use are each selected by 10.5%, while poor instillation technique observed in clinic is selected by 8.8%.

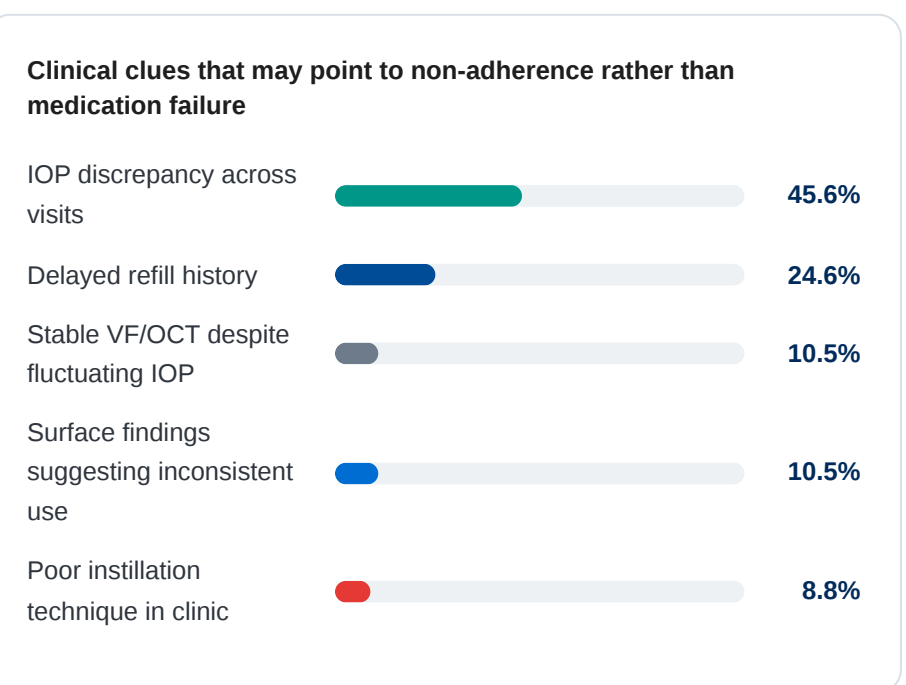
THE INSIGHT

No single signal proves that a patient is missing treatment. The clinical value comes from triangulation: pressure behavior, refill timing, visual-field or OCT trajectory, ocular-surface findings, the number of bottles, and what happens when the patient demonstrates their technique. When several of these point in the same direction, the probability that the pathway is failing because of use rather than pharmacology becomes more persuasive.

WHY IT MATTERS

Misclassifying non-adherence as medication failure can lead to escalation that increases burden without restoring consistency. The survey therefore supports an adherence check before the clinician concludes that the pressure-lowering mechanism itself has failed.

Clinical clues that may point to non-adherence rather than medication failure



04

FIRST TREATMENT ADJUSTMENT

The first response to drop difficulty is usually to simplify the regimen or reduce dependence on it

40.4% first consolidate therapy into once-daily dosing or a fixed-dose combination; 38.6% move toward a procedural option such as SLT.

CONTEXT

When a patient is struggling with tolerability or dosing schedules, the next decision is often not simply which drug to add. It is whether the treatment should become easier to administer or whether the patient should be less dependent on daily administration at all. That distinction becomes more important as the regimen expands from one bottle to several.

WHAT THE DATA SHOWS

Consolidating therapy into once-daily dosing or a fixed-dose combination leads at 40.4%, but moving toward a procedural option such as SLT follows closely at 38.6%. Switching to preservative-free glaucoma medication is selected by 15.8%, while introducing an administration aid or adherence device is selected by 5.3%.

THE INSIGHT

The near tie between simplification and procedural reduction of drop burden is one of the clearest strategic signals in the survey. Ophthalmologists are not treating adherence only as a patient-behavior problem. They are changing the treatment architecture: fewer doses, fewer bottles, or a pathway that can lower IOP without requiring the same daily action.

WHY IT MATTERS

Each route has different trade-offs. Simplification preserves topical therapy but may not solve ocular-surface disease or physical administration difficulty. SLT can reduce medication dependence in selected patients but requires procedure acceptance, access, and an appropriate glaucoma profile. The key is matching the source of the burden to the intervention that can actually reduce it.

Default first adjustment when tolerability or dosing schedules become difficult

40.4% Consolidate to once-daily or fixed-dose combination	**38.6%** Move toward SLT or another procedural option
15.8% Switch to preservative-free medication	**5.3%** Introduce an administration aid or adherence device

05

OCULAR SURFACE DISEASE

Surface management is often a treatment redesign, not an add-on

35.7% rapidly transition to preservative-free glaucoma medication when chronic topical therapy is associated with ocular surface disease.

CONTEXT

For a patient with burning, hyperemia, dryness, or chronic discomfort, continued exposure to the same topical regimen can create a feedback loop: treatment causes or worsens symptoms, symptoms reduce persistence, and inconsistent use produces more uncertainty about pressure control. The ophthalmologist then has to decide whether to treat the surface around the glaucoma regimen or change the regimen itself.

WHAT THE DATA SHOWS

Rapid transition to preservative-free glaucoma medication is the most selected strategy at 35.7%. Concurrent dry-eye or other OSD therapy follows at 28.6%. Reducing topical medication burden through SLT or another procedure accounts for 21.4%, and switching medication class or formulation to reduce preservative-related exposure accounts for 14.3%.

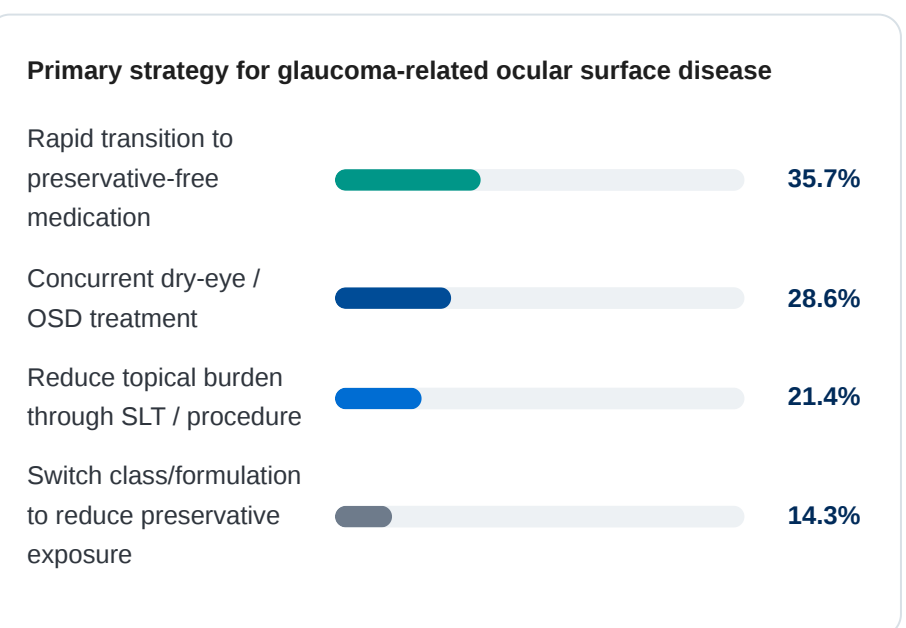
THE INSIGHT

These responses show three different ways to solve the same surface problem: remove the preservative, treat the ocular surface, or reduce topical exposure altogether. A 2024 systematic review found that chronic benzalkonium-chloride-containing glaucoma therapy can contribute to ocular-surface disease and that preservative-free or less cytotoxic formulations can improve ocular-surface outcomes. The survey shows how that evidence is translated into real treatment choices.

WHY IT MATTERS

OSD can influence adherence, quality of life, examination findings, and willingness to remain on therapy. Managing it early may therefore protect both the ocular surface and the reliability of the pressure-lowering plan.

Primary strategy for glaucoma-related ocular surface disease



06

SLT POSITIONING

SLT is moving earlier in the pathway, but patient acceptance is still a major implementation barrier

40.0% use SLT as a first-line option before initiating topical therapy, and another 40.0% consider it early when non-adherence or OSD becomes evident.

CONTEXT

SLT has shifted from being viewed only as an escalation after multiple medications to a treatment that can be discussed earlier. NICE recommends 360° SLT as initial treatment for selected newly diagnosed ocular hypertension at risk and non-advanced chronic open-angle glaucoma, while an American Academy of Ophthalmology review supports the long-term effectiveness of SLT as primary or supplemental therapy in open-angle glaucoma. The six-year LiGHT trial also found durable drop-free control in many eyes treated initially with SLT.

WHAT THE DATA SHOWS

The survey mirrors that broader shift. Forty percent use SLT first-line before topical therapy, and 40.0% consider it early when non-adherence or OSD becomes evident. Only 16.4% use it mainly as an adjunct when medical therapy is insufficient or poorly tolerated, and 3.6% reserve it primarily for selected advanced or surgically high-risk cases. Yet 44.4% identify patient reluctance or concern about laser or procedural interventions as the biggest barrier to using procedural options earlier.

THE INSIGHT

The gap is therefore not simply clinician awareness. In this respondent group, SLT is already conceptually early. The challenge is converting that position into an accepted patient pathway. That requires a clear explanation that SLT may reduce or delay drop dependence but does not guarantee permanent medication-free control, and that repeat treatment or additional therapy may still be needed.

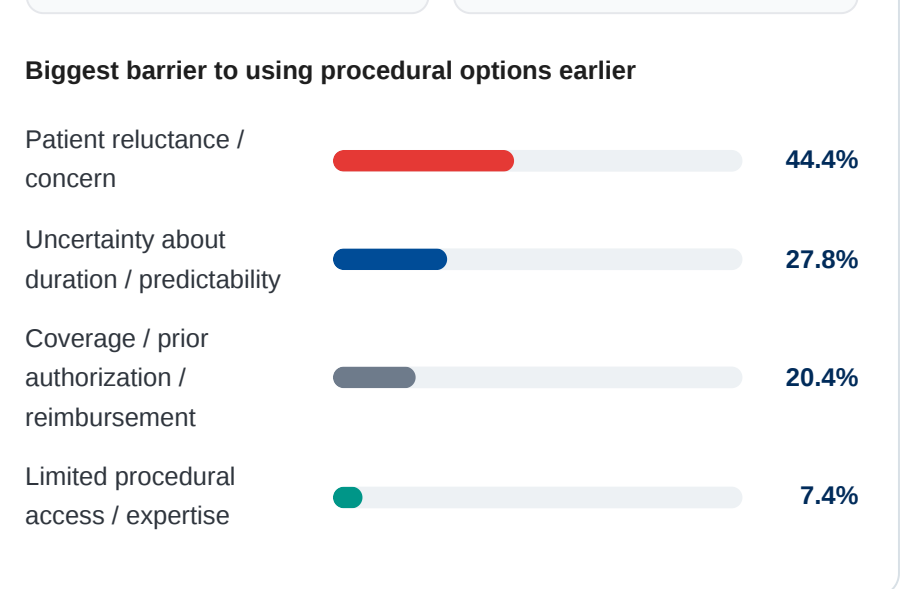
WHY IT MATTERS

Earlier procedural care changes the consultation. Rather than introducing laser only after the patient has struggled with drops, the ophthalmologist can discuss it as one of the initial or early choices, with trade-offs that are compared before adherence becomes a crisis.

How SLT is positioned when adherence or tolerability is a concern

40.0% First-line before topical therapy	**40.0%** Considered early when non-adherence or OSD appears
16.4% Mainly an adjunct after medical therapy	**3.6%** Reserved mainly for selected advanced/high-risk cases

Biggest barrier to using procedural options earlier



07

SUSTAINED-RELEASE THERAPY

Sustained-release delivery is being considered for specific adherence problems, but it is not yet routine across practice

24.1% say sustained-release options are rarely or not yet used in their practice; among specific patient profiles, dexterity or cognitive limitations are the most selected prompt at 22.2%.

CONTEXT

Sustained-release glaucoma therapy changes the adherence equation by moving some or all of the pressure-lowering effect away from daily self-administration. That makes it particularly relevant when the treatment is effective in principle but the patient cannot reliably instill or remember it. The available technologies, repeat-dosing rules, indications, and access vary substantially by market, so use cannot be generalized across countries.

WHAT THE DATA SHOWS

The largest single response is that sustained-release options are rarely or not yet used, at 24.1%. Among patient profiles that prompt consideration, significant physical dexterity or cognitive limitations lead at 22.2%, followed by documented non-adherence with a high risk of progression at 20.4%, severe OSD or drop intolerance despite preservative-free therapy at 18.5%, and the need for additional IOP lowering after SLT without increasing drop burden at 14.8%.

THE INSIGHT

The pattern shows that sustained release is not being framed simply as a convenience technology. The leading clinical use cases are patients for whom daily administration is structurally difficult or unsafe to rely on. A U.S. regulatory example is the travoprost intracameral implant iDose TR, approved by the FDA in 2023 for lowering IOP in open-angle glaucoma or ocular hypertension. Other markets and products differ, reinforcing the need for local regulatory and patient-specific assessment.

WHY IT MATTERS

As these options expand, the key question will be not only whether the implant lowers IOP, but which patients gain the most from transferring adherence responsibility away from the daily drop. That requires matching duration, safety, anatomy, pressure target, previous treatment, and access to the patient's specific adherence barrier.

Patient profiles that prompt consideration of sustained-release delivery

22.2% Physical dexterity or cognitive limitations	**20.4%** Documented non-adherence with high progression risk
18.5% Severe OSD or drop intolerance despite PF therapy	**14.8%** Need more IOP lowering after SLT without more drops

24.1% report that sustained-release options are rarely or not yet used in their practice.

08

NEXT 3–5 YEARS

Ophthalmologists expect earlier SLT to reduce drop dependence more than any single medication innovation

46.3% choose earlier use of SLT as part of initial glaucoma management as the development most likely to reduce long-term eye-drop dependence.

CONTEXT

The future of adherence could be approached in two ways: make daily topical treatment easier, or reduce how much daily topical treatment is required. The survey asks which development is most likely to matter over the next 3–5 years, and the strongest signal favors the second approach.

WHAT THE DATA SHOWS

Earlier SLT as part of initial glaucoma management leads at 46.3%. Longer-acting sustained-release drug delivery follows at 25.9%. More effective once-daily or fixed-dose topical therapy is selected by 14.8%, and wider adoption of MIGS or other pressure-lowering procedures by 13.0%.

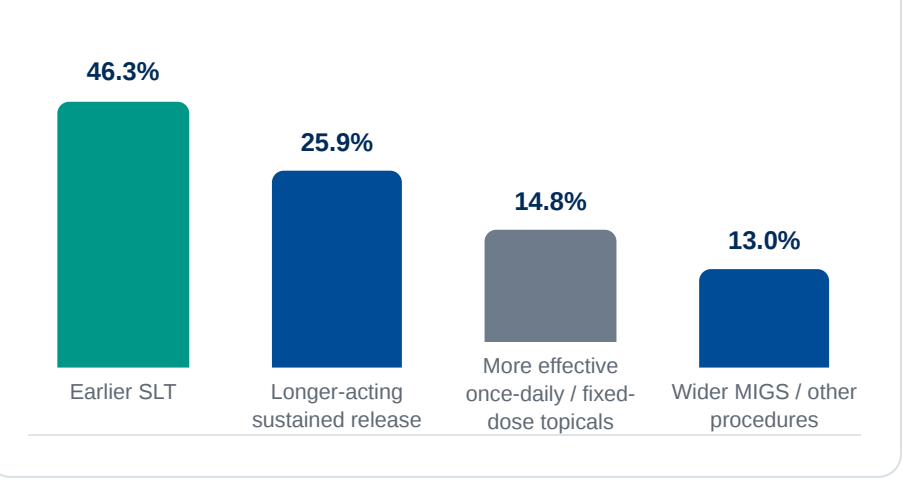
THE INSIGHT

The ordering suggests that respondents see the next major adherence gain as a change in treatment timing rather than only a change in formulation. Better bottles, fixed-dose combinations, and longer-acting delivery still matter, but the leading response is to move an established non-drop option earlier in the disease journey.

WHY IT MATTERS

The practical challenge is to turn that direction into a patient-selection pathway. Earlier SLT will only reduce treatment burden when the patient is an appropriate candidate, understands what the procedure can and cannot do, and can access it without introducing new delays or inequities. The same principle applies to sustained-release therapy and MIGS: reducing adherence burden should not mean bypassing individualized risk-benefit assessment.

Developments most likely to reduce dependence on long-term glaucoma eye drops



OPEN-ENDED ANALYSIS

When ophthalmologists describe a glaucoma case where adherence changed the course, they repeatedly return to pressure variability, technique, surface burden, and the decision to reduce drop dependence.

Respondents were asked to think of a glaucoma patient whose IOP control or disease management was significantly affected by poor eye-drop adherence, describe what revealed the adherence problem, what change they made, and what ultimately had the greatest impact on care.

Pressure and progression exposed the gap

Several responses describe elevated or fluctuating IOP, visual-field progression, or structural change despite an apparently adequate prescribed regimen as the signal that adherence needed to be investigated.

Patient admission and refill behavior mattered

Some patients acknowledged missed doses, inconsistent use, or difficulty maintaining the schedule. Family or caregiver discussions also helped uncover what was happening between visits.

Instillation technique was part of the problem

Responses mention observing poor drop technique and using in-clinic demonstration, education, or family support to improve administration rather than assuming the drug itself was inadequate.

Ocular-surface symptoms changed therapy

Burning or ocular-surface disease led some clinicians to reduce preservative exposure, move to preservative-free therapy, or otherwise simplify topical treatment.

SLT or surgery reduced dependence on drops

Multiple responses describe introducing SLT, laser, MIGS, or surgery after adherence problems became clear, especially when IOP or progression remained concerning.

The most effective change was individualized

The qualitative responses do not support one universal solution. The useful intervention depended on whether the barrier was technique, tolerability, memory, regimen complexity, or the need for a more durable non-drop strategy.

> The qualitative responses reinforce the quantitative story: the practical goal is not simply to identify non-adherence, but to change the treatment design so pressure control depends less on the barrier that caused the problem.

FREQUENTLY ASKED QUESTIONS

Frequently asked questions about glaucoma eye-drop adherence and reducing drop burden.

Why do patients have difficulty adhering to glaucoma eye drops?

Glaucoma treatment is often long term, while the disease may cause few symptoms until damage is advanced. Adherence can be affected by ocular-surface discomfort, complex schedules, difficulty instilling drops, refill or cost barriers, limited perceived benefit, and treatment fatigue.

Can ocular surface disease affect glaucoma medication adherence?

Yes. Burning, dryness, hyperemia, irritation, and other ocular-surface symptoms can make chronic topical therapy harder to sustain. Clinicians may respond by reducing preservative exposure, simplifying therapy, treating ocular-surface disease, or considering non-drop options when appropriate.

What is selective laser trabeculoplasty for glaucoma?

Selective laser trabeculoplasty, or SLT, is a laser procedure that targets the trabecular meshwork to lower intraocular pressure in open-angle glaucoma or ocular hypertension. It can be used as initial treatment or as an alternative or adjunct to pressure-lowering eye drops in selected patients.

Can SLT reduce the need for glaucoma eye drops?

SLT can reduce or delay the need for topical medication in some patients, although additional treatment may still be needed over time. The expected benefit depends on the glaucoma type, baseline pressure, treatment target, prior therapy, and individual response.

When are preservative-free glaucoma drops considered?

Preservative-free formulations may be considered when preservatives contribute to clinically significant ocular-surface disease or when tolerability is limiting long-term treatment. The choice still depends on the required pressure reduction, medication class, availability, and local guidance.

What are sustained-release treatments for glaucoma?

Sustained-release glaucoma treatments are designed to lower intraocular pressure without relying on daily eye-drop administration for the full treatment effect. Available options and indications vary by country and product, and patient selection depends on anatomy, prior treatment, pressure goals, safety considerations, and local approval.

GLAUCOMA PRACTICE LENS

What this means at four decision points in long-term glaucoma care.

The survey does not define one treatment algorithm. It does show where ophthalmologists repeatedly need to distinguish pharmacologic failure from treatment-use failure and decide whether to simplify, protect the ocular surface, or reduce dependence on daily drops.

When IOP is unexpectedly high or variable

Check whether the treatment is reaching the eye consistently. Review refill timing, dosing routine, technique, surface symptoms, and structural or functional trajectory before assuming the medication class is inadequate.

When the ocular surface is deteriorating

Treat surface burden as part of the glaucoma pathway. Consider preservative exposure, formulation, dry-eye management, bottle count, and whether reducing topical therapy would make the pressure-lowering plan more sustainable.

When the regimen becomes harder to sustain

Choose between simplification and dependence reduction. A once-daily or fixed-dose regimen may solve schedule complexity; SLT may solve the need for daily self-administration in an appropriate patient.

When discussing laser or sustained release earlier

Explain the trade-off before adherence has already failed. Set expectations about duration, need for additional treatment, procedure risks, local availability, and how the option fits the patient's disease stage and pressure target.

CLOSING PERSPECTIVE

The next adherence gain may come from redesigning glaucoma treatment around the patient rather than asking the patient to fit an increasingly complex regimen.

The survey describes an adherence problem that begins long before a patient openly says they are missing drops. It can first appear as fluctuating IOP, delayed refills, ocular-surface discomfort, poor instillation technique, or progression that does not match the apparent intensity of treatment.

That matters because each signal points to a different next step. Ocular-surface disease may call for preservative reduction or surface treatment. Regimen complexity may call for once-daily therapy or a fixed-dose combination. Physical or cognitive limitations may make sustained-release delivery more relevant. And when the central problem is the dependence on daily drops itself, SLT can move from an escalation option to an earlier strategic choice.

The survey also shows why the shift is not automatic. Patient reluctance is the leading barrier to earlier procedural treatment, and respondents still express uncertainty around the duration and predictability of IOP-lowering benefit. Coverage and access remain relevant as well. Moving a procedure earlier in the pathway therefore requires more than evidence that it works. It requires clear patient communication, appropriate selection, local capacity, and a treatment plan for what happens if the effect wanes.

The external evidence is moving in the same direction. NICE already recommends 360° SLT as initial treatment in selected newly diagnosed OHT and non-advanced COAG. The American Academy of Ophthalmology has reported strong evidence for SLT as primary or supplemental therapy in open-angle glaucoma. Longer-term LiGHT trial data support durable disease control for many patients treated first with SLT. At the same time, modern ocular-surface literature continues to highlight the burden of chronic preserved topical therapy, while sustained-release technologies are expanding the set of options that do not depend on daily instillation.

For ophthalmologists, the bigger story is therefore not a competition between drops and procedures. It is a move toward matching the pressure-lowering strategy to the barrier most likely to undermine it. The treatment that looks simplest on a prescription may not be the treatment the patient can sustain. Long-term glaucoma control becomes more reliable when adherence, tolerability, technique, and treatment burden are treated as clinical variables from the beginning.

Help future ophthalmology insights reflect what makes long-term glaucoma treatment sustainable.

Share your clinical perspective with MDForLives and contribute to future healthcare insights shaped by real ophthalmology practice.

Join the Panel

REFERENCES AND DATA SOURCE

Sources used for this report

1. **MDForLives internal survey report.** All Markets Report for SGID 8977449, Project: Engagement Campaign | Ophthalmology Insight Survey_Sept. 69 survey records, 71% completion rate, across 6 countries: USA · UK · Canada · Italy · France · Germany. Question-level response totals vary. Internal operational, required-text, after-question, and honeypot fields were excluded.
2. **National Institute for Health and Care Excellence (NICE).** Glaucoma: diagnosis and management (NG81). The guideline recommends 360° SLT for selected newly diagnosed OHT and non-advanced COAG and emphasizes assessment of adherence and instillation technique when control is inadequate. NICE glaucoma recommendations.
3. **American Academy of Ophthalmology.** Takusagawa HL, et al. Selective Laser Trabeculoplasty for the Treatment of Glaucoma: A Report by the American Academy of Ophthalmology. Ophthalmology. 2024;131(1):37–47. PubMed record.
4. **LiGHT Trial.** Gazzard G, et al. Six-Year Results of Primary Selective Laser Trabeculoplasty versus Eye Drops for the Treatment of Glaucoma and Ocular Hypertension. Ophthalmology. 2023;130(2):139–151. PubMed record.
5. **Ocular-surface evidence.** Kemer ÖE, et al. Managing Ocular Surface Disease in Glaucoma Treatment: A Systematic Review. Bioengineering. 2024;11(10):1010. PubMed record.
6. **U.S. Food and Drug Administration.** iDose TR (travoprost intracameral implant), approval package; approved December 13, 2023 for reduction of elevated IOP in open-angle glaucoma or ocular hypertension. FDA approval package.

MDForLives

The Global Pulse of Healthcare

MDForLives is a global healthcare insights platform where healthcare professionals, patients, and caregivers discover, share, and shape the future of healthcare.

This report presents aggregated perspectives for professional insight and discussion. It is not clinical guidance, treatment advice, or a substitute for patient-specific judgement, approved product information, or local practice standards.

© 2026 MDForLives

A Borderless Access platform

Real Opinions to Insights. Validated by Data.