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Six years of wearer experience in children participating in a myopia control study of MiSight® 1 day

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ABSTRACT

Purpose: To evaluate the experience of children wearing soft contact lenses (CLs) during a trial of MiSight® 1 day (omafilcon A, CooperVision, Inc.), a dual-focus myopia-control daily disposable CL.

Methods: A 3-year, double-masked, randomised trial (Part 1) comparing experiences with MiSight 1 day and a single-vision control (Proclear® 1 day, omafilcon A, CooperVision, Inc.) of neophyte, myopic children (ages 8–12). Treatment (n = 65) and control (n = 70) participants received lenses at sites in Canada, Portugal, Singapore, and the UK. Successful participants completing Part 1 were invited to continue for a further 3 years wearing the dual-focus CL (Part 2), and 85 participants completed the 6-year study. Children and parent questionnaires were conducted at baseline, 1 week, 1 month, and every 6 months until the 60-month visit, with children only also completing questionnaires at 66 and 72 months.

Results: Throughout the study, children reported high satisfaction with handling (≥89% top 2 box [T2B]), comfort (≥94% T2B), vision (≥93% T2B for various activities), and overall satisfaction (≥97% T2B). Ratings for comfort and vision were not significantly different between lens groups, visits, or study parts and did not change when children switched to dual-focus CLs. Ratings for 'really easy' or 'kind of easy' application improved from the outset for the neophytes (57% at 1-week follow-up and 85% at 1-month follow-up) and remained high throughout the study (visit: P = 0.007; part: P = 0.0004). Overall satisfaction improved in Part 2 (P = 0.04). Wearing times increased in Part 2 (14 vs. 13 hrs/weekday; 13 vs. 12 hrs/day on weekends; P < 0.001); there were no differences between groups.

Conclusions: Children adapted rapidly to full-time wear, rated lenses highly, and rarely reported issues. The dual-focus optics included in the MiSight® 1 day lenses successfully achieved myopia control without lowering subjective ratings when fitted to neophytes or children refitted from single-vision CLs.

1. Introduction

In addition to accurate correction of refractive errors [1], soft contact lenses (SCLs) can provide children with various benefits compared to spectacles, including improvements in vision quality [1], self-perception [2], and quality of life [3–5]. Despite these potential benefits, only a small proportion (~7%) of SCL fittings are for children aged 14 years or under [6]. Furthermore, a 2020 study reported that only 2.3% of children globally wearing SCLs were fitted for myopia management [7], a surprisingly small proportion given the alarming rise in the prevalence of myopia [8]. Recent (2021) data from the UK revealed that approximately 20% of soft lenses being prescribed to children aged 14 years or under were for myopia management [6].

The limited SCL fits among children may reflect concerns of eye care professionals (ECPs) and parents about complications and ocular health, handling, chair-time, compliance, and/or costs [9–11]. Also, some ECPs may be concerned about the need for specialist fitting skills or equipment, hesitancy of parents, as well as whether refractive outcomes are less predictable when fitting SCLs for myopia management [9–11]. Financial considerations, eye care professional (ECP) time constraints,

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and lack of familiarity with and availability of myopia-control therapies may also play a role [12].

Research suggests that SCL wear is at least as safe for children and teenagers as it is for adults – if not safer – [13–17] and that risks of wearing CLs to manage myopia are less than the risks of high myopia if myopia is allowed to progress untreated [18,19]. Similarly, the impact of SCLs on children's ocular physiology is minimal and no different to SCL wearers of any age [1,3,17,20,21]. Children generally prefer SCL over spectacle lens corrections [1,22] and even young children can successfully handle SCLs [1,2]. ECPs require similar amounts of chair-time when fitting children and teenagers, although staff members may need to spend more time (+10 min) with children when teaching lens application and removal [20]. Most significantly, children can achieve full-time wear [1,3–5,22–24], which may facilitate the efficacy of myopia-control lenses [25,26].

An increased motivation to fit young myopes with myopia-control SCLs could see many children refitted to these lenses. However, few studies have compared the subjective experience of children between myopia-control CLs and single-vision correction [27–29], and fewer still have compared this among children crossing over between single-vision SCLs and myopia-control SCLs [30]. The present study evaluated the subjective experiences of children wearing single-vision or myopia-control daily disposable SCLs, including daily wear time, perceived vision quality, ease of handling, and overall satisfaction. Moreover, this 6-year study compared experiences between those fitted with myopia-control lenses and a matched cohort who transitioned from single vision to myopia-control lenses at the 3-year study mid-point.

2. Methods

Part 1 of this study was a 3-year, multicentre, double-masked, randomised clinical trial of myopia management CLs in children aged 8–12 years at baseline [23], which compared a dual-focus myopia-control lens (MiSight® 1 day, omafilcon A, CooperVision, Inc.) with a single-vision control (Proclear® 1 day, omafilcon A, CooperVision, Inc.). Part 2 was an open-label, non-randomised study; all participants successfully completing Part 1 were invited to continue for a further 3 years wearing the dual-focus CL [31]. Methods and results for these studies have been published previously [23,31]. Both parts of the study were conducted at the same four investigational sites: University of Minho, Portugal; Aston University, United Kingdom; National University Hospital, Singapore; and the University of Waterloo, Canada. The cohort of children who received MiSight 1 day lens treatment throughout the entire 6 years is referred to as T6; the cohort of children who first received single-vision, control lenses and then 3 years of MiSight 1 day lens treatment is referred to as T3.

At Part 1 baseline, the targeted study population was healthy children aged 8 to 12 years with −0.75 D to −4.00 D of myopia and<1.00 D of astigmatism. Further inclusion criteria were best-corrected visual acuity by manifest refraction of at least + 0.10 logMAR in each eye, <1.00 D of anisometropia, and agreeing to wear the assigned CLs for a minimum of 10 hrs/day and at least 6 days/week. Exclusion criteria included previous or current wear of contact lenses; concomitant participation in another clinical trial or participation within 30 days prior to enrolment; parent/guardian or their close relative being a member of the investigation staff; and past or present use of any other myopia-control treatment. Participants who completed the 3-year visit of Part 1 were invited to enrol in Part 2.

Questionnaires were administered in person to participants at baseline, 1 week, 1 month, and every 6 months up to 72-months to assess wearing time, ease of handling, comfort, and satisfaction with vision and overall experience. Questions asked about time of application and time of removal (from which wearing time was calculated), ease of applying and removing lenses, average number of lens-wear days per week, comfort, and a series of questions about their visual experiences, including how much they noticed visual disturbances (ghosting or haloes or glare). Response options for subjective questions used a five-point Likert scale in an expanded format; response options for each item were positively worded and negatively worded answers to a direct question. Child-friendly language was used to aid understanding and pictures to support the explanations if deemed necessary. The participants were given ample time to complete the questionnaire by themselves; a member of the site staff was available to answer any queries and to help the participant understand the question but were instructed not to help the participant with the answer. This paper reports the children's responses for almost all aspects of the questionnaire; the exception is for "How often do you lose or tear your contact lenses?". As might be expected, few children reported that they often lost or damaged their contact lenses.

Parents or the guardian accompanying the child to an appointment completed a similar questionnaire. Parents were asked how frequently they needed to assist their child with applying and removing lenses. Also, parents were asked to estimate how happy they thought their child was with CLs in terms of comfort, vision, and overall satisfaction. In addition, parents were asked to report their own comfort level regarding their child wearing contact lenses apart from the final two visits.

The statistical analyses were undertaken using SAS software (SAS 9.4, SAS Institute). The subjective questionnaire responses were compared using generalised models. The responses were dichotomised with the top-two-box and a binary distribution was used. The model included the fixed effects: group, time, site, and part, and interactions of time, site and part with lens group. A p-value of 0.050 or less was taken to indicate a statistically significant difference. Although participants were questioned every 6 months, only annual data are reported for the sake of brevity as results were consistent between visits.

This clinical study was designed and conducted in conformance with the ethical principles in the Declaration of Helsinki, with the International Council for Harmonisation (ICH) guidelines for Good Clinical Practice (GCP), and all applicable local regulations. Favourable reviews of the study protocol and informed consent documents were obtained from appropriate legally constituted Research Ethics Committees at each investigational site prior to commencing the study. An assent document was explained to, read, and signed by each potential participant prior to enrolment in each part of the study. Similarly, an informed consent document was explained to, read, understood, and signed by a parent or legal guardian of the participant prior to enrolment.

3. Results

3.1. Demographics

There were no statistically significant differences between control and treatment groups in Part 1 (Baseline) with respect to age, sex, ethnicity, refraction, or axial length. By 36 months, the only statistically significant differences between groups were higher levels of myopia and longer axial lengths in the previously untreated control cohort (Table 1).

3.2. Discontinuations

Overall, the retention rate for those participants enrolled and dispensed lenses in each part of the study was high: 81% for Part 1 (109/135) and 79% (85/108) for Part 2. In Part 1, 82% (53/65) of the dual-focus group and 80% (56/70) of the single-vision group completed the 36-month visit. In Part 2, 77% (40/52) of the T6 group and 80% (45/56) of the T3 group completed the 72-month visit. Prior to these discontinuations, nine participants discontinued from the study before lenses were dispensed in Part 1. Fig. 1 summarises the flow of participants through the study, with reasons for discontinuations. Lens-related discontinuations from Part 2 were due to unacceptable vision (four T3, one T6), preference for spectacles (two T6), discomfort (one T3), unacceptable lens fit (one T3), and participant or parent/guardian decision (one T3). The small number of discontinuations prevented formal

Table 1
Summary of demographics at baseline for Part 1 and at 36 months for Part 2.

Variable		Part 1 – Study Lens Group		Part 2 –Study Lens Group	
		Single-Vision (T3)	Dual-Focus (T6)	Dual-Focus (T3)	Dual-Focus (T6)
No. of Participants		74	70	56	52
No. of Eyes		148	140	112	104
Participant Age (yrs.)	Mean (SD)	10.1 (1.4)	10.1 (1.3)	13.0 (1.5)	13.2 (1.3)
Sex (n (%))	Male	37 (50%)	38 (54%)	27 (48%)	28 (54%)
	Female	37 (50%)	32 (46%)	29 (52%)	24 (46%)
Ethnicity of Participant (n (%))	White European	40 (54%)	39 (56%)	34 (61%)	28 (54%)
	East Asian	18 (24%)	16 (23%)	9 (16%)	11 (21%)
	South Asian	7 (9%)	5 (7%)	6 (11%)	5 (10%)
	Other	4 (5%)	2 (3%)	2 (4%)	2 (4%)
	Mixed	5 (7%)	8 (11%)	5 (9%)	6 (12%)
Cycloplegic Rx - Spherical Equivalent (D)	Mean (SD)	−2.19 (0.81)	−2.02 (0.77)	−3.45 (1.14)	−2.52 (0.98)
Axial Length (mm)	Mean (SD)	24.42 (0.66)	24.46 (0.70)	25.07 (0.74)	24.76 (0.66)

T3: participant group randomised to single-vision control lens for first 3 years and then switched to dual-focus test lens for the following 3 years.
T6: participant group randomised to dual-focus test lens for first 3 years and then continued with test lens for the following 3 years.

statistical analyses.

3.3. Wearing times

On average, weekday and weekend wearing times increased throughout the 6-year study (both groups, $p < 0.001$). Average wear times during the school week increased from 13 h per day early in the study to approximately 14 h per day at study completion (Fig. 2). Average wear times were less on the weekend ($p < 0.0001$) but also increased across the 6 years, from 12 h per day early in the study to 13 h per day at study completion. There were no statistically significant differences in wear time between T3 and T6 groups ($p > 0.14$). On average, participants wore their lenses between 6 and 7 days per week.

3.4. Handling

After 1 month of wear, children reported high ratings for ease of handling, and it continued to be satisfactory throughout the study. There were no differences between groups and no change in rating for handling performance when children were switched into dual-focus CLs. At the 1-month visit, 82% of the T3 group and 85% of the T6 answered the question "How easy is it to put the lenses on your eyes?" with 'kind of easy' or 'really easy'. There were significant differences for application by visit ($P = 0.007$) in the first few months of wear, with participants finding it easier the longer they were in the study. There were few difficulties with removal of lenses ('How easy is it to take the lenses off your eyes?'), with the proportion of children who described lens removal as 'kind of easy' or 'really easy' reaching 100% by 1 month.

The younger participants learned to apply their contact lenses quickly; 56–57% found lens application 'easy' by week 1, and this improved to 82–85% by 1 month, indicating a rapid improvement in skill levels. Age did not affect handling ratings; similar proportions of younger (8–10 years at recruitment) and older (11–12 years at recruitment) children rated the dual-focus lenses as 'really easy' or 'kind of easy' to apply and remove in Part 1 of the study ($P > 0.25$). Removal ratings by age group were 95% or greater for the first few visits and remained high for all visits.

Parents were asked how many times per month they needed to apply their child's lenses; from 1 month, 80% or more parents needed to intervene less than once a month, which had increased to 90% or more by 6 months. For removal, 94% or more from the 1-month visit said they needed to intervene less than once a month. Investigators at study sites reported that children required more support from parents at the beginning of the study, but there was minimal involvement with lens application and removal after 1 month in both groups.

3.5. Comfort

Comfort was rated highly in both groups throughout the study. When participants were asked 'how much can you feel the lenses on your eyes?', a majority (≥94%) in each group answered 'don't notice them' or 'sometimes' throughout the study. 'Don't notice them' was a majority response for both groups at nine of the twelve follow-up visits, with proportions ranging from 43% to 70%; 'sometimes notice them' ranged from 28% to 55%. No participants reported 'They bother me a lot'. Additionally, participants were asked whether the lenses made their eyes 'itch, burn or feel dry'. A majority in each group responded 'hardly ever' or 'sometimes' to this question (98% in T3 and 94% in T6 across all visits). There were no significant differences between treatment and control groups in Part 1, nor when wearers were switched from the control to the dual-focus lens, nor between visits or study parts. Parents' observations mirrored their child's acceptance of CL wear. Parents were asked 'how happy do you think your child is in terms of comfort of the lenses', to which over 94% in each group reported 'somewhat happy' or 'extremely happy' throughout the study.

Few participants discontinued for reasons of comfort. In Part 1, one single-vision lens wearer discontinued at the 24-month visit citing comfort as the main reason. One participant discontinued at the point of being switched into the dual-focus lens, citing comfort and vision.

3.6. Subjective vision

Over 90% of participants rated themselves as seeing 'kind of well' or 'really well' in each group for assessments of vision during schoolwork, outdoor activities, watching TV/movies, playing video games, and reading. 'Really well' was a majority response at all visits, ranging from 61% to 94%, while 'kind of well' ranged from 6% to 37%. This was mirrored by the parents' observation of their child's acceptance of CL wear reported on the parents' questionnaire. At least 98% of parents in both groups said they thought their children were 'extremely' or 'somewhat happy' with CLs in terms of vision. Ratings were high from the start and remained high for all (five) vision questions, with no significant differences between groups, visits, or study part. On comparing the 36-month and 42-month data within the T3 group, there were no significant differences in vision ratings caused by switching lens type ($P > 0.10$). Three participants out of a total of 5 (60%) who discontinued at the point of being switched cited vision as the main reason with one further participant citing vision as a secondary reason for discontinuation.

Visual disturbances (ghosting ["double images"], haloes ["a ring or circle of light"] or glare ["dazzling light"]) were reported to be 'not noticeable' or 'noticeable but not annoying' by at least 90% of children across the study visits (Fig. 3). In Part 1, few children reported that disturbances were 'annoying' or 'very annoying' for either the dual-focus (8/1,034 reports) or single-vision (1/488 reports) lenses. In Part 2, there were few reports that disturbances were 'annoying' or 'very annoying' in the T6 group (2/280 reports) and none in the T3 group (0/292 reports). There were no significant differences between the lens types or study parts, including no significant difference between study parts for the T3 group. Children rarely needed to remove CLs due to unsatisfactory vision, with at least 84% of parents reporting this

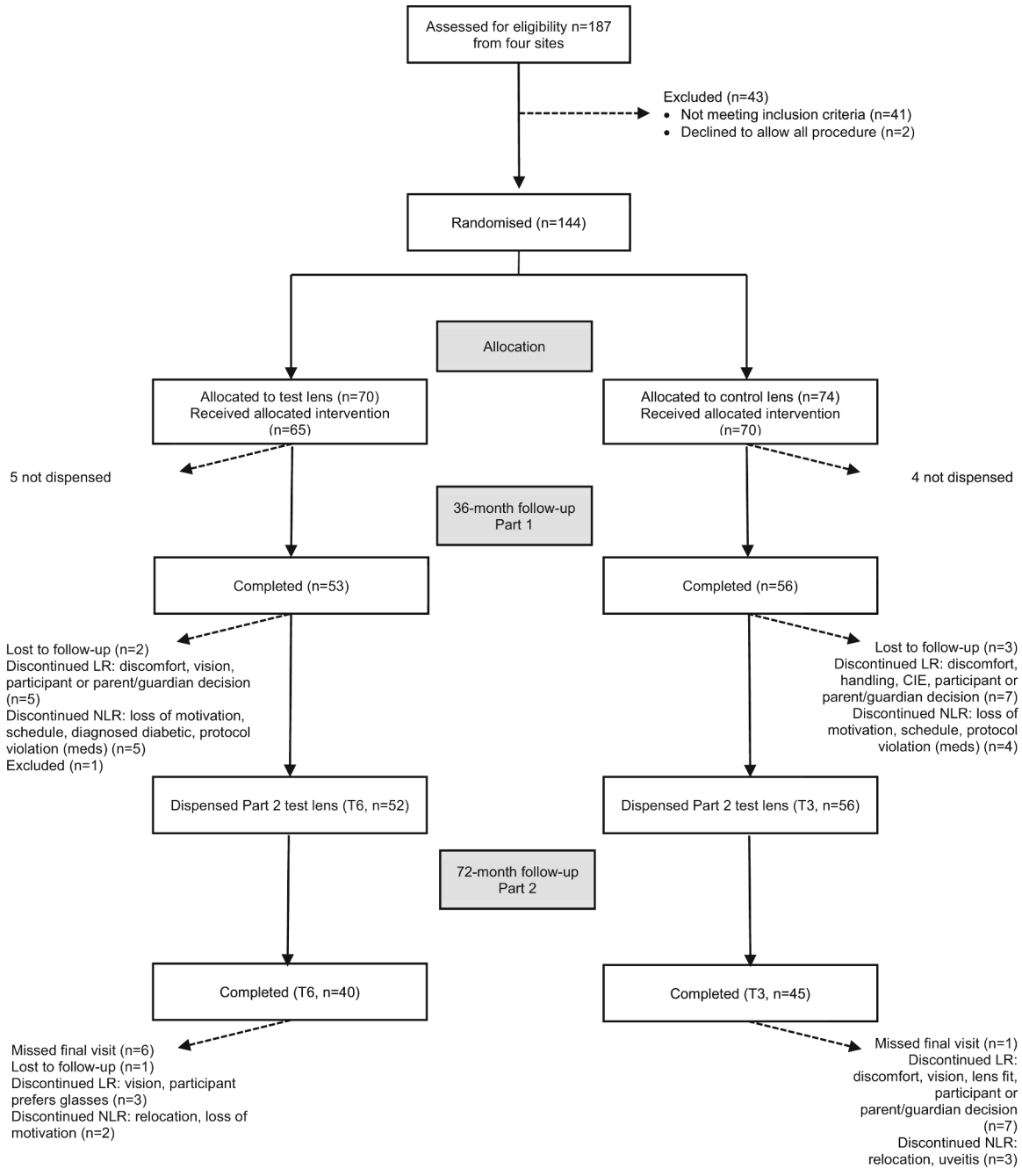


Fig. 1. Flowchart of treatment allocations and participant numbers for Parts 1 and 2 in the MiSight 1 day 6-year clinical study. T3: participant group randomised to single-vision control lens for first 3 years and then switched to dual-focus test lens for following 3 years. T6: participant group randomised to dual-focus test lens for first 3 years and then continued with test lens for following 3 years. LR: Lens related discontinuations (e.g., comfort, vision, fit). NLR: Non lens related discontinuations (e.g., relocation, medication).

occurred less than once a month from the 1-week visit.

3.7. Visual acuity

At the Part 1 dispensing visit, mean monocular distance visual acuity with CLs was −0.04 logMAR for both treatment and control groups. Mean distance visual acuity upon presentation was slightly better with dual-focus lenses at some follow-up visits (Fig. 4) since participants wearing the single-vision lens experienced larger progression of myopia between study visits, presenting with greater levels of under-corrected

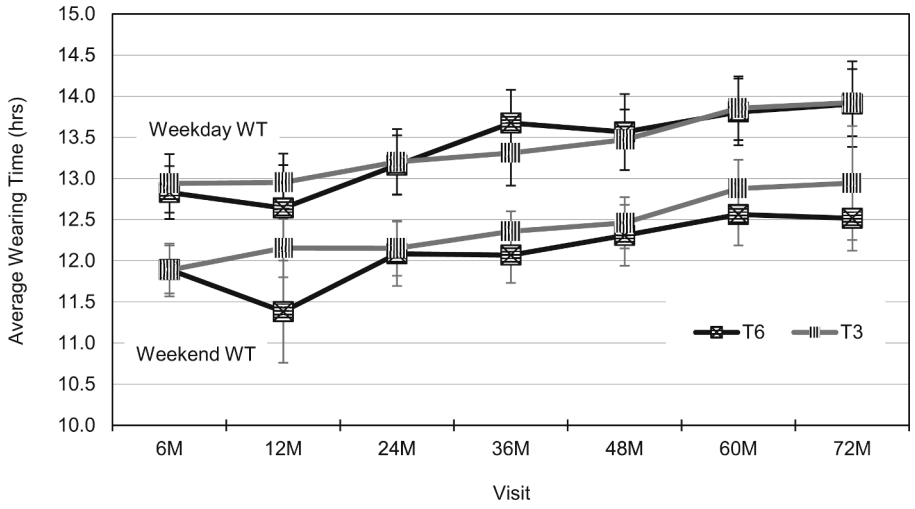


Fig. 2. Average daily wearing times (WT) on weekdays and weekends in the MiSight 1 day clinical study. T3: participant group randomised to single-vision control lens for first 3 years and then switched to dual-focus test lens for the following 3 years. T6: participant group randomised to dual-focus test lens for first 3 years and then continued with test lens for the following 3 years.

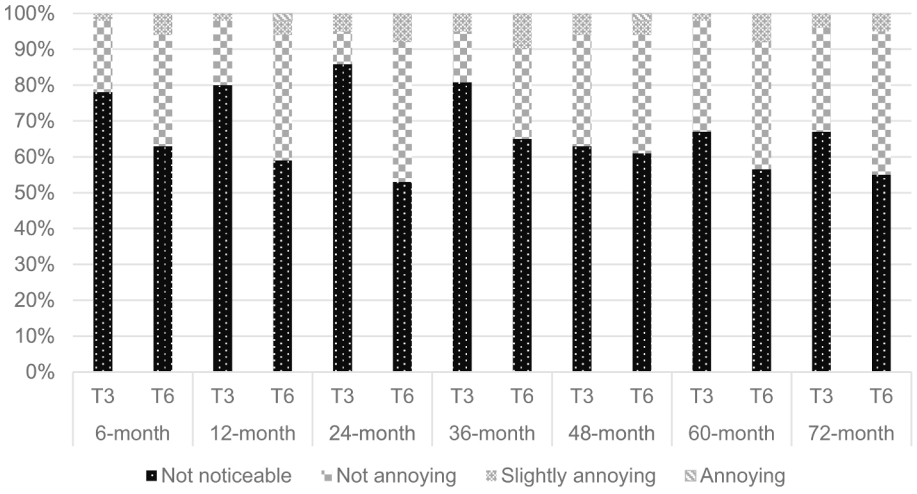


Fig. 3. Noticeability/annoyance related to observed visual disturbances: 'How much do you notice ghosting, haloes or glare when you are wearing your contact lenses?' by lens group in the MiSight 1 day clinical study. T3: participant group randomised to single-vision control lens for first 3 years and then switched to dual-focus test lens for the following 3 years. T6: participant group randomised to dual-focus test lens for first 3 years and then continued with test lens for the following 3 years.

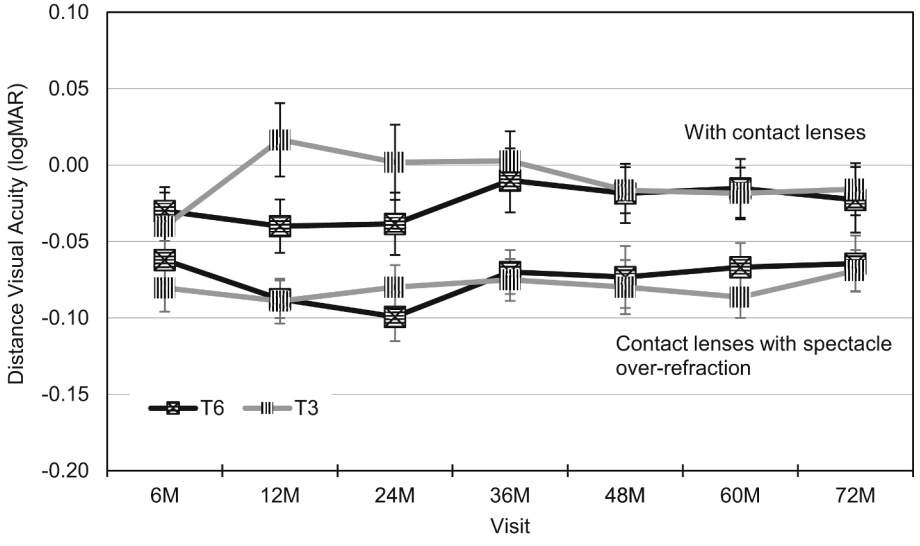


Fig. 4. Distance visual acuity (logMAR, monocular) with contact lenses prior to spherical over-refraction and with spectacle over-refraction by lens group in the MiSight 1 day clinical study. T3: participant group randomised to single-vision control lens for first 3 years and then switched to dual-focus test lens for following 3 years. T6: participant group randomised to dual-focus test lens for first 3 years and then continued with test lens for following 3 years. N. B.: A lower logMAR indicates a better visual acuity.

myopia. With over-refraction, average distance visual acuity remained similar for the two lens types, being within one letter at each visit.

In Part 2, both distance and near visual acuity with dual-focus lenses were, on average, similar in both groups (T3 and T6) – within 1 letter at each visit. When comparing visual acuity with sphero-cylindrical spectacle refraction, both contact lenses enabled visual acuity within half a line of that observed with the sphero-cylindrical spectacle over-correction (Fig. 4). There were no differences in visual acuity across visits.

3.8. Overall satisfaction with contact lenses

After the first week of lens wear, over 95% of participants in each group responded positively when asked 'how much do you like wearing your CLs?' (Fig. 5). The responses were similar for each group throughout the study. Switching lens type did not cause a significant difference in satisfaction; similar proportions of children selected 'I like them best' after 3 years' wear of single-vision lenses (88%, 49/56) and one subsequent year's wear of dual-focus lenses (84%, 43/51; $P = 0.64$). A similar question was asked about wearing their spectacles (Fig. 5), and satisfaction levels were considerably lower ($p < 0.05$). This was mirrored by the parents' observation of their child's acceptance of CLs. Over 90% of parents in each group at each visit thought their children were 'Extremely happy' or 'Somewhat happy' with their CLs overall.

3.9. Children's activities

Children reported engaging in a wide range of activities over the 6-year study with the number of hours spent on some activities increasing over time (e.g., sport) but remaining similar for others. [32] It is interesting to note, although probably not surprising, that time spent reading for pleasure reduced as children got older, and more time was spent doing homework at the weekend.

3.10. Parental assurance

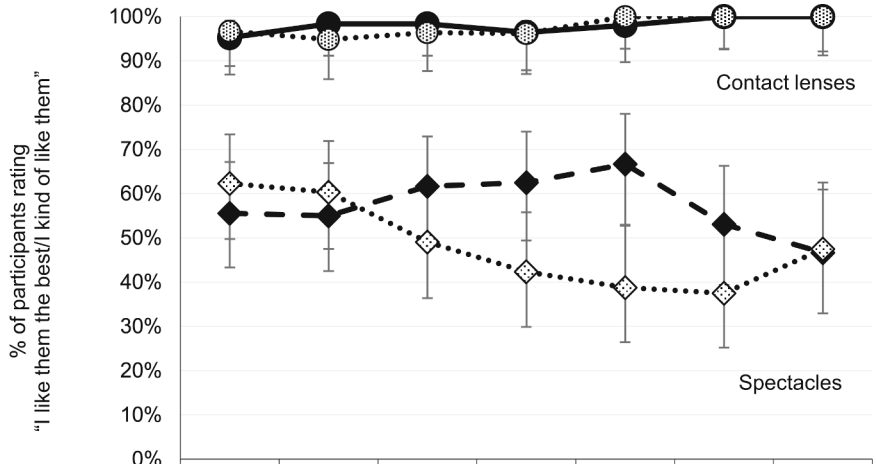
Parents' confidence with their child wearing lenses increased during the study compared to baseline, prior to beginning lens wear. At baseline, 79% of parents were either extremely or somewhat comfortable with the prospect of their child wearing contact lenses. From the 1-month visit onwards, over 98% of parents felt extremely or somewhat comfortable with their child wearing contact lenses.

Throughout the study, large proportions of parents reported that they believed their child to be happy with their contact lenses. The proportions of parents reporting that their child was extremely or somewhat happy with CLs in terms of comfort, vision and overall ranged from 93% to 100%. Stratified by study group, the proportion of parents selecting 'extremely happy' with comfort ranged, from the 1-month visit onwards, from 61% to 79% for T6 and from 71% to 88% for T3. Likewise, 'extremely happy' with vision ranged, from the 1-month visit onwards, from 75% to 90% for T6 and from 78% to 94% for T3. Lastly, 'extremely happy' overall ranged, from the 1-month visit onwards, from 73% to 92% for T6 and from 85% to 96% for T3.

4. Discussion

The trial found that myopic children, aged 8 to 12 years at initial fitting, adapt well to full-time daily disposable SCL wear and can switch easily from single-vision CLs to dual-focus myopia-control CLs (MiSight® 1 day). Throughout the study, children reported long wearing times and rated SCL wear highly. The results suggest that children can achieve wearing times equal to those of adults; in Part 2 of the current study, the children, who were then 11-to-16-year-olds, had wearing times of 14 h per day – wearing times as long as those of a group of mostly adult CL wearers [33,34]. The results suggest that contact lenses were well suited to the children's lifestyle and life stage, especially as the children's engagement in various activities changed over the 6 years. For example, as the children got older, they spent less time reading for pleasure and more time participating in activities where being spectacle-free was likely to be beneficial, such as sport. The study findings are consistent with those of several previous studies reporting on children confirming good comfort [1,24], good handling [1,4,5,24], acceptable vision [1,24], and overall satisfaction when wearing soft CLs [3–5,24].

Furthermore, the results demonstrate the adaptability of children switching to different designs and support the practice of moving adapted myopic contact lens wearers into a myopia-control



	6-month	12-month	24-month	36-month	48-month	60-month	72-month
T3 CL	95%	98%	98%	96%	98%	100%	100%
T6 CL	97%	95%	96%	96%	100%	100%	100%
T3 Spectacles	56%	55%	62%	63%	67%	53%	47%
T6 Spectacles	62%	60%	49%	42%	39%	38%	48%

Fig. 5. Percent of reports of "like them the best" or "I kind of like them" when questioned about overall satisfaction with wearing contact lenses or spectacles. T3: participant group randomised to single-vision control lens for first 3 years and then switched to dual-focus test lens for the following 3 years. T6: participant group randomised to dual-focus test lens for first 3 years and then continued with test lens for the following 3 years.

intervention. Of particular note is the retention rate (80%) of the T3 group after they had moved from 3 years of single-vision contact lens wear into a dual-focus design. Four participants discontinued after switching from single vision to a dual-focus contact lens design at 36 months citing vision as an important reason. However, reassurance from investigators lead to a vast majority of participants adapting quickly to dual-focus lens wear and completing the study. The data suggest that some children became aware of visual disturbances when switching into dual-focus contact lenses but were not bothered by them. Given that visual compromise may intensify symptoms of CL discomfort [35], the finding that comfort with the study lenses was not affected by switching lens type is consistent with the finding that subjective vision quality was also not affected.

Handling is an important, but often overlooked, factor that is key to retention among new wearers and is often a needless concern for parents and children [12]. Although the early days of contact lens handling were not 'easy', the children learnt quickly and became confident at handling by the one-month mark. In studies considering additional aspects of handling, children (age 8–12 years at baseline) report better handling with CLs than with spectacles [4,5] since the slightly longer application and removal times are outweighed by CLs being less frequently lost or broken than spectacles [4].

There are limitations to the study findings that should be considered when interpreting the results. Importantly, interpretation of this study – with respect to refitting children to a dual-focus, myopia-control contact lens – is limited to refitting successful single-vision contact lens wearers; further study would be needed to examine fitting this lens among other groups, such as older children with less or no contact lens wear experience. In addition, two outcomes were subject to selection bias: wear time and parent ease with the concept of their children wearing CLs. Parental concern was a somewhat self-selecting condition as the greater the parent unease, the less likely they would be to agree to enrol their child in the clinical trial. Investigators reported that for many parents, there was an element of seeing the benefit of myopia control and wanting their child to take part in the study for that reason, although some did express concerns about their children wearing SCLs. Nonetheless, parent ease improved by 1 month. As for wear time, the study criteria included those participants who agreed to wear the assigned CLs for a minimum of 10 hrs/day for at least 6 days/week (to ensure maximum treatment effect). Nevertheless, on average, children wore their lenses several hours longer than this minimum agreed wear time, and wear time increased throughout the study. Another possible limitation is that investigator interaction with participants was not scripted, and its effect on patient responses is unknown. Additionally, there was no spectacle control group, although all participants were single-vision spectacle wearers prior to enrolment, which acted as a reference point during Part 1. Another limitation to consider is the potential for self-reporting bias inherent in studies that use questionnaires. Although this study administered questionnaires to children and parents independently, the apparent mirroring of the children's ratings of CL wear by parent observations could be caused by parent–child interaction outside of the study visits. In contrast, the strength of the conclusions is supported by the consistency of the results throughout the long, 6-year study period.

5. Conclusion

Daily disposable soft contact lenses are well accepted by children, regardless of the optical design of the lens. Children can handle their SCLs, achieve full-time wear, and generally preferred their SCLs to spectacles. SCLs are rated highly for all aspects of wear experience, including handling ease, comfort, vision, and overall satisfaction, and this continues when switching from a single-vision lens to MiSight® 1 day, a dual-focus, myopia-control design. With the due care and consideration appropriate for all CL wear, ECPs and parents can be confident that SCL wear is a viable option for children. ECPs should also be confident to offer such myopia management SCLs to existing single-vision SCL, paediatric, myopic patients.

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