



White paper on

**Menicon Bloom™ Myopia Control Management System**

May 2019

**For journalist use**

**Disclaimer**

This white paper contains proprietary information from Menicon Co., Ltd. on 'Menicon Bloom Myopia Control Management System' and is intended for journalist use. Neither Menicon Co., Ltd. nor any person acting on the company's behalf may be held responsible for the use which may be made of the information contained herein. If you require further information or have received this document in error, please notify Menicon Co., Ltd. on the contact details provided below. Thank you for your understanding.

Craig Smith  
Global Marketing Department  
Menicon Co., Ltd.  
Email: [newbusiness@menicon.co.jp](mailto:newbusiness@menicon.co.jp)  
Tel: +81-52-935-1676  
[www.menicon.com](http://www.menicon.com)



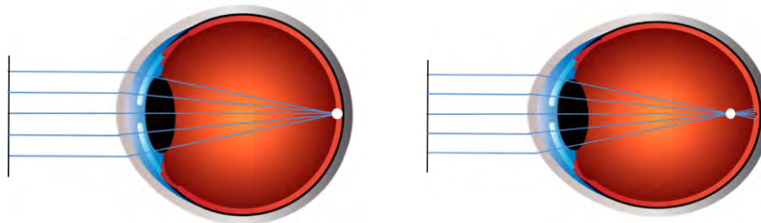
## Introduction

Menicon Co., Ltd. is concerned with the growing incidence of myopia and its health consequences worldwide, and has thus dedicated significant resources to develop the Menicon Bloom Myopia Control Management System, a holistic approach for myopia control management. This system features the initial introduction of Menicon Bloom Night, the first and only CE-approved orthokeratology contact lens for myopia control management. The CE approval also allows Menicon to prepare regulatory submissions to launch Menicon Bloom Night in additional countries, including Australia, New Zealand, Hong Kong, Singapore, Malaysia and others. The rationale for the launch and the details of this myopia care therapy are explained in this white paper.

## What Is Myopia?

Myopia, also known as near- or short-sightedness, is the most common refractive error and the major cause of vision impairment worldwide (1, 2). Globally, it is recognized as a significant public health concern associated with increased ocular-related morbidity and considerable healthcare costs (3-6). It affects approximately 30% of the world's population and its prevalence has been forecast to affect about 50% of the world's population by 2050 (1). The prevalence of myopia in young adolescents has been increasing in recent decades to about 30% in industrialized societies of the West and epidemic levels of over 90% in some parts of Far East Asia (1, 7-12).

Myopia is a condition in which incoming light focuses in front of, rather than on, the retina as a result of the eye being too long for its refractive power (Figure 1) (6). This causes blurred distance vision while objects at near may appear clear. Myopia normally develops during childhood and progresses until the mid to late teenage years (13, 14), with younger children and females showing greater annual rates of myopia progression (15).



**Figure 1.** The image on the left shows the refractive status of an emmetropic eye where light rays entering the eye focus on the retina, whereas the image on the right represents a myopic eye where light rays entering the eye focus in front of the retina causing blurred distance vision.

## What Causes Myopia?

The underlying cause behind the onset and progression of myopia is believed to be a combination of genetic and environmental factors (16). Risk factors include ethnicity, number of myopic parents, time engaged in close work, lack of time spent outdoors, and country and location (i.e., urban/rural) of residency (17-25). Of particular concern is the association of increasing levels of myopia with a higher risk of potentially blinding ocular pathologies such as glaucoma, myopic maculopathy, and vitreous and retinal detachments (5, 26-30). Furthermore, high myopia has also been found to contribute to a general degradation of quality of life due to psychological, cosmetic and practical reasons (31).

## How Can Myopia Be Detected?

Qualified eye care professionals can diagnose myopia through an eye examination. Whilst the refractive state of myopic individuals can be successfully corrected to achieve acceptable distance vision by conventional spectacles or contact lenses, these remedies are not intended to control myopia progression. On the contrary, in some cases these optical devices may exacerbate the progression of myopia (25, 32, 33). There is evidence indicating myopia can be mitigated by having children spend more time outdoors and through the use of specialized optical devices and medicines (25, 33).

There is strong scientific evidence from case reports, retrospective studies, prospective clinical trials and meta-analyses that overnight orthokeratology contact lens wear is a successful treatment option for myopia control in children and young adults (32, 34, 35). There is also growing evidence on the long-term efficacy of overnight orthokeratology for myopia control (36-39). However, there are currently very limited treatment options that have official regulatory approval for myopia control (40).

### **How Does Menicon Bloom Night Work?**

Menicon Bloom Night therapy involves the overnight wear of a specially designed orthokeratology contact lens manufactured in hyper oxygen permeable Menicon Z material to ensure optimal corneal oxygenation for safe and comfortable lens wear (41-45). The treatment temporarily changes the shape of the cornea by flattening and steepening the central and mid-peripheral corneal curvatures, respectively. These corneal changes occur overnight and reduce refractive error, thus eliminating the need to wear contact lenses throughout the waking hours after lenses are removed (46). The new corneal shape also provides a particular optical path for incoming light that counters the ocular growth response associated with myopia development (47).

Menicon Bloom Night is indicated for the correction of refractive myopia and for the control of myopia when prescribed and managed by a qualified eye care professional.

Menicon Bloom Night myopia control therapy is currently available in two different contact lens designs: Menicon Bloom Night and Menicon Bloom Night Toric. Both lens types can correct up to -4.00D of myopia, with Menicon Bloom Night Toric providing additional options for correcting higher levels of corneal and refractive astigmatism.

### **Is Menicon Bloom Night Safe and Effective?**

Menicon Bloom Night contact lenses have been reviewed and validated via numerous comprehensive, peer-reviewed studies related to myopia control management. These studies provide conclusive support for the safety and efficacy of this treatment for myopia control management (37, 48-59).

#### **Safety**

Like any other treatment, Menicon Bloom Night can be associated with the development of adverse events and complications. However, recent large studies, including meta-analyses and systematic reviews, have demonstrated that Menicon Bloom Night type contact lenses, if fitted correctly by an eye care professional according to the manufacturer's instructions, are safe to use in younger populations (60-62). Specific studies performed with Menicon Bloom Night for myopia control management have shown that the complications associated with the use of the device are typically not considered to be serious; are similar to those reported with other contact lens types; and can be managed straightforwardly in clinical practice (50, 52, 53). Additionally, post-marketing surveillance and complaint trend data from the manufacturer as well as potential adverse events reported with Menicon Bloom Night orthokeratology contact lenses in external databases have been reviewed. Analysis of all this data has provided conclusive evidence supporting Menicon Bloom Night as a safe, viable myopia control treatment option (63).

#### **Effectiveness**

Several peer-reviewed studies specifically conducted with Menicon Bloom Night for myopia control treatment have demonstrated significant levels of efficacy (50, 51, 53). Furthermore, recent results demonstrate the successful long-term efficacy of Menicon Bloom Night at reducing myopia progression in children (37). All together, these studies have provided consistent evidence supporting the efficacy of the treatment for myopia control management.

With the accumulation of long-term and comprehensive scientific evidence over the years, Menicon Bloom Night has met the highest standards of safety, efficacy and quality required to grant the treatment CE approval for myopia control management in Europe. Menicon Bloom Night, if used correctly in accordance with the instructions for use, provides excellent benefits with very limited risks.

#### **How Well is Menicon Bloom Night Accepted?**

Menicon Bloom Night therapy has shown to be well-accepted by parents and to improve children's self-esteem in terms of physical appearance, participation in activities, academic performance and peer perception (55).

#### **How & Who Can Fit Menicon Bloom Night?**

The fitting of Menicon Bloom Night is optimized by the use of a corneal topographer to precisely measure corneal shape, in conjunction with Easyfit software, a sophisticated, user-friendly tool which accurately guides the eye care professional through the fitting process. Additionally, a specially designed mobile phone application, Menicon's Virtual Doctor, has been developed to enhance the monitoring and communication process between eye care professionals and patients. Menicon Bloom Night is only available for certified eye care professionals.

#### **Why CE Approval Matters**

Marketing a medical device in Europe requires a marketing authorization ('product license') for specified indications under specified conditions (e.g., target population, indication, specific use), regulated by the European Medical Agency (64, 65). This process is employed to ensure that medical products meet the highest standards of safety, efficacy and quality before being issued a marketing authorization. In Europe, products that hold a marketing authorization are designated a 'CE' marking.

Prescribing a licensed product outside the approved scope of use is called 'off-label' prescribing. An example of off-label prescribing occurs when an orthokeratology contact lens, which is approved for the correction of manifest myopia in adults, is prescribed for reducing myopia progression in children, where both the indication (i.e., correcting manifest myopia vs. reducing myopia progression) and target group (i.e., adults vs. children) are different from those for which the product has been approved for.

When prescribing a treatment for myopia control, the eye care professional should ideally start by considering all on-label products that may be available and only contemplate off-label prescribing if there are no on-label options or if approved products are not effective or appropriate (40). In off-label prescribing, the patient must be adequately informed about the lack of product authorization and the possible existence of unknown risks (66-70). Parents and legal guardians should be informed of all options and associated risks in order to decide whether the child should be treated with a tested and approved on-label treatment or with an off-label treatment that might give a successful result, but has unknown risks.

With the official marketing authorization for myopia control management, Menicon Bloom Night has met the highest standards of safety, efficacy and quality required to grant the treatment CE approval for myopia control management in Europe. With such approval, eye care professionals can now have peace of mind with the on-label prescription of this myopia control therapy.

\* Bloom, Bloom Night, Menicon Z and Easyfit are trademarks of Menicon Co., Ltd.

## References

1. Holden BA, Fricke TR, Wilson DA, Jong M, Naidoo KS, Sankaridurg P, et al. Global prevalence of myopia and high myopia and temporal trends from 2000 through 2050. *Ophthalmology*. 2016;123(5):1036-42.
2. Flaxman SR, Bourne RRA, Resnikoff S, Ackland P, Braithwaite T, Cicinelli MV, et al. Global causes of blindness and distance vision impairment 1990-2020: a systematic review and meta-analysis. *Lancet Glob Health*. 2017;5(12):e1221-e34.
3. Vitale S, Cotch MF, Sperduto R, Ellwein L. Costs of refractive correction of distance vision impairment in the United States, 1999-2002. *Ophthalmology*. 2006;113(12):2163-70.
4. Lim MC, Gazzard G, Sim EL, Tong L, Saw SM. Direct costs of myopia in Singapore. *Eye (Lond)*. 2009;23(5):1086-9.
5. Flitcroft DI. The complex interactions of retinal, optical and environmental factors in myopia aetiology. *Prog Retin Eye Res*. 2012;31(6):622-60.
6. Flitcroft DI, He M, Jonas JB, Jong M, Naidoo K, Ohno-Matsui K, et al. IMI - Defining and classifying myopia: a proposed set of standards for clinical and epidemiologic studies. *Invest Ophthalmol Vis Sci*. 2019;60(3):M20-M30.
7. Pan CW, Dirani M, Cheng CY, Wong TY, Saw SM. The age-specific prevalence of myopia in Asia: a meta-analysis. *Optom Vis Sci*. 2015;92(3):258-66.
8. Koh V, Yang A, Saw SM, Chan YH, Lin ST, Tan MM, et al. Differences in prevalence of refractive errors in young Asian males in Singapore between 1996-1997 and 2009-2010. *Ophthalmic Epidemiol*. 2014;21(4):247-55.
9. Pan CW, Ramamurthy D, Saw SM. Worldwide prevalence and risk factors for myopia. *Ophthalmic Physiol Opt*. 2012;32(1):3-16.
10. Wang TJ, Chiang TH, Wang TH, Lin LL, Shih YF. Changes of the ocular refraction among freshmen in National Taiwan University between 1988 and 2005. *Eye (Lond)*. 2009;23(5):1168-9.
11. Vitale S, Sperduto RD, Ferris FL, 3rd. Increased prevalence of myopia in the United States between 1971-1972 and 1999-2004. *Arch Ophthalmol*. 2009;127(12):1632-9.
12. Gilmartin B. Myopia: precedents for research in the twenty-first century. *Clin Exp Ophthalmol*. 2004;32(3):305-24.
13. Goss DA, Winkler RL. Progression of myopia in youth: age of cessation. *Am J Optom Physiol Opt*. 1983;60(8):651-8.
14. Group C. Myopia stabilization and associated factors among participants in the Correction of Myopia Evaluation Trial (COMET). *Invest Ophthalmol Vis Sci*. 2013;54(13):7871-84.
15. Donovan L, Sankaridurg P, Ho A, Naduvilath T, Smith EL, 3rd, Holden BA. Myopia progression rates in urban children wearing single-vision spectacles. *Optom Vis Sci*. 2012;89(1):27-32.
16. Tedja MS, Haarman AEG, Meester-Smoor MA, Kaprio J, Mackey DA, Guggenheim JA, et al. IMI - Myopia genetics report. *Invest Ophthalmol Vis Sci*. 2019;60(3):M89-M105.
17. Rose KA, Morgan IG, Smith W, Burlutsky G, Mitchell P, Saw SM. Myopia, lifestyle, and schooling in students of Chinese ethnicity in Singapore and Sydney. *Arch Ophthalmol*. 2008;126(4):527-30.
18. French AN, Morgan IG, Mitchell P, Rose KA. Risk factors for incident myopia in Australian schoolchildren: the Sydney adolescent vascular and eye study. *Ophthalmology*. 2013;120(10):2100-8.
19. Mutti DO, Hayes JR, Mitchell GL, Jones LA, Moeschberger ML, Cotter SA, et al. Refractive error, axial length, and relative peripheral refractive error before and after the onset of myopia. *Invest Ophthalmol Vis Sci*. 2007;48(6):2510-9.
20. He M, Zheng Y, Xiang F. Prevalence of myopia in urban and rural children in mainland China. *Optom Vis Sci*. 2009;86(1):40-4.
21. Gwiazda J, Hyman L, Dong LM, Everett D, Norton T, Kurtz D, et al. Factors associated with high myopia after 7 years of follow-up in the Correction of Myopia Evaluation Trial (COMET) Cohort. *Ophthalmic Epidemiol*. 2007;14(4):230-7.

22. Pacella R, McLellan J, Grice K, Del Bono EA, Wiggs JL, Gwiazda JE. Role of genetic factors in the etiology of juvenile-onset myopia based on a longitudinal study of refractive error. *Optom Vis Sci.* 1999;76(6):381-6.
23. Wu MM, Edwards MH. The effect of having myopic parents: an analysis of myopia in three generations. *Optom Vis Sci.* 1999;76(6):387-92.
24. Rosenfield M, Gilmartin B. *Myopia and nearwork.* Oxford, UK.: Butterworth-Heinemann; 1998.
25. Gifford KL, Richdale K, Kang P, Aller TA, Lam CS, Liu YM, et al. IMI - Clinical management guidelines report. *Invest Ophthalmol Vis Sci.* 2019;60(3):M184-M203.
26. Tano Y. Pathologic myopia: where are we now? *Am J Ophthalmol.* 2002;134(5):645-60.
27. Vongphanit J, Mitchell P, Wang JJ. Prevalence and progression of myopic retinopathy in an older population. *Ophthalmology.* 2002;109(4):704-11.
28. Wong TY, Klein BE, Klein R, Knudtson M, Lee KE. Refractive errors, intraocular pressure, and glaucoma in a white population. *Ophthalmology.* 2003;110(1):211-7.
29. Saw SM, Gazzard G, Shih-Yen EC, Chua WH. Myopia and associated pathological complications. *Ophthalmic Physiol Opt.* 2005;25(5):381-91.
30. Ikuno Y, Jo Y, Hamasaki T, Tano Y. Ocular risk factors for choroidal neovascularization in pathologic myopia. *Invest Ophthalmol Vis Sci.* 2010;51(7):3721-5.
31. Rose K, Harper R, Tromans C, Waterman C, Goldberg D, Haggerty C, et al. Quality of life in myopia. *Br J Ophthalmol.* 2000;84(9):1031-4.
32. Huang J, Wen D, Wang Q, McAlinden C, Flitcroft I, Chen H, et al. Efficacy comparison of 16 interventions for myopia control in children: a network meta-analysis. *Ophthalmology.* 2016;123(4):697-708.
33. Wildsoet CF, Chia A, Cho P, Guggenheim JA, Polling JR, Read S, et al. IMI - Interventions myopia institute: interventions for controlling myopia onset and progression report. *Invest Ophthalmol Vis Sci.* 2019;60(3):M106-M31.
34. Si JK, Tang K, Bi HS, Guo DD, Guo JG, Wang XR. Orthokeratology for myopia control: a meta-analysis. *Optom Vis Sci.* 2015;92(3):252-7.
35. Wen D, Huang J, Chen H, Bao F, Savini G, Calossi A, et al. Efficacy and acceptability of orthokeratology for slowing myopic progression in children: a systematic review and meta-Analysis. *J Ophthalmol.* 2015;2015:360806.
36. Hiraoka T, Kakita T, Okamoto F, Takahashi H, Oshika T. Long-term effect of overnight orthokeratology on axial length elongation in childhood myopia: a 5-year follow-up study. *Invest Ophthalmol Vis Sci.* 2012;53(7):3913-9.
37. Santodomingo-Rubido J, Villa-Collar C, Gilmartin B, Gutierrez-Ortega R, Sugimoto K. Long-term efficacy of orthokeratology contact lens wear in controlling the progression of childhood myopia. *Curr Eye Res.* 2017;42(5):713-20.
38. Hiraoka T, Sekine Y, Okamoto F, Mihashi T, Oshika T. Safety and efficacy following 10-years of overnight orthokeratology for myopia control. *Ophthalmic Physiol Opt.* 2018;38(3):281-9.
39. Lee YC, Wang JH, Chiu CJ. Effect of Orthokeratology on myopia progression: twelve-year results of a retrospective cohort study. *BMC Ophthalmol.* 2017;17(1):243.
40. Jones L, Drobe B, Gonzalez-Meijome JM, Gray L, Kratzer T, Newman S, et al. IMI - Industry guidelines and ethical considerations for myopia control report. *Invest Ophthalmol Vis Sci.* 2019;60(3):M161-M83.
41. Ladage PM, Yamamoto K, Ren DH, Li L, Jester JV, Petroll WM, et al. Effects of rigid and soft contact lens daily wear on corneal epithelium, tear lactate dehydrogenase, and bacterial binding to exfoliated epithelial cells. *Ophthalmology.* 2001;108(7):1279-88.
42. Morgan PB, Maldonado-Codina C, Efron N. Comfort response to rigid and soft hyper-transmissible contact lenses used for continuous wear. *Eye Contact Lens.* 2003;29(1 Suppl):S127-30; discussion S43-4, S92-4.
43. Maldonado-Codina C, Morgan PB, Efron N, Efron S. Comparative clinical performance of rigid versus soft hyper Dk contact lenses used for continuous wear. *Optom Vis Sci.* 2005;82(6):536-48.



44. Morgan PB, Efron N, Maldonado-Codina C, Efron S. Adverse events and discontinuations with rigid and soft hyper Dk contact lenses used for continuous wear. *Optom Vis Sci.* 2005;82(6):528-35.
45. Albright RA, Venuti BD, Ichijima H, Nyunt AK, Cavanagh HD. Postmarket surveillance of Menicon Z rigid gas-permeable contact lenses for up to 30 days continuous wear in the United States. *Eye Contact Lens.* 2010;36(5):241-4.
46. Swarbrick HA. Orthokeratology review and update. *Clin Exp Optom.* 2006;89(3):124-43.
47. Smith EL, 3rd. Optical treatment strategies to slow myopia progression: effects of the visual extent of the optical treatment zone. *Exp Eye Res.* 2013;114:77-88.
48. Chan KY, Cheung SW, Cho P. Clinical performance of an orthokeratology lens fitted with the aid of a computer software in Chinese children. *Cont Lens Anterior Eye.* 2012;35(4):180-4.
49. Chen CC, Cheung SW, Cho P. Toric orthokeratology for highly astigmatic children. *Optom Vis Sci.* 2012;89(6):849-55.
50. Cho P, Cheung SW. Retardation of myopia in Orthokeratology (ROMIO) study: a 2-year randomized clinical trial. *Invest Ophthalmol Vis Sci.* 2012;53(11):7077-85.
51. Santodomingo-Rubido J, Villa-Collar C, Gilmartin B, Gutierrez-Ortega R. Myopia control with orthokeratology contact lenses in Spain: refractive and biometric changes. *Invest Ophthalmol Vis Sci.* 2012;53(8):5060-5.
52. Santodomingo-Rubido J, Villa-Collar C, Gilmartin B, Gutierrez-Ortega R. Orthokeratology vs. spectacles: adverse events and discontinuations. *Optom Vis Sci.* 2012;89(8):1133-9.
53. Chen C, Cheung SW, Cho P. Myopia control using toric orthokeratology (TO-SEE study). *Invest Ophthalmol Vis Sci.* 2013;54(10):6510-7.
54. Santodomingo-Rubido J, Villa-Collar C, Gilmartin B, Gutierrez-Ortega R. Factors preventing myopia progression with orthokeratology correction. *Optom Vis Sci.* 2013;90(11):1225-36.
55. Santodomingo-Rubido J, Villa-Collar C, Gilmartin B, Gutierrez-Ortega R. Myopia control with orthokeratology contact lenses in Spain: a comparison of vision-related quality-of-life measures between orthokeratology contact lenses and single-vision spectacles. *Eye Contact Lens.* 2013;39(2):153-7.
56. Santodomingo-Rubido J, Villa-Collar C, Gilmartin B, Gutierrez-Ortega R. Short-term changes in ocular biometry and refraction after discontinuation of long-term orthokeratology. *Eye Contact Lens.* 2014;40(2):84-90.
57. Santodomingo-Rubido J, Villa-Collar C, Gilmartin B, Gutierrez-Ortega R, Suzaki A. The effects of entrance pupil centration and coma aberrations on myopic progression following orthokeratology. *Clin Exp Optom.* 2015;98(6):534-40.
58. Santodomingo-Rubido J, Villa-Collar C, Gilmartin B, Gutierrez-Ortega R. Short-term and long-term changes in corneal power are not correlated with axial elongation of the eye induced by orthokeratology in children. *Eye Contact Lens.* 2016.
59. Santodomingo-Rubido J, Villa-Collar C, Gilmartin B, Gutierrez-Ortega R, Suzaki A. Short- and long-term changes in corneal aberrations and axial length induced by orthokeratology in children are not correlated. *Eye Contact Lens.* 2017;43(6):358-63.
60. Bullimore MA, Sinnott LT, Jones-Jordan LA. The risk of microbial keratitis with overnight corneal reshaping lenses. *Optom Vis Sci.* 2013;90(9):937-44.
61. Li SM, Kang MT, Wu SS, Liu LR, Li H, Chen Z, et al. Efficacy, safety and acceptability of orthokeratology on slowing axial elongation in myopic children by meta-analysis. *Curr Eye Res.* 2016;41(5):600-8.
62. Liu YM, Xie P. The safety of orthokeratology--a systematic review. *Eye Contact Lens.* 2016;42(1):35-42.
63. File MDo. Clinical evaluation report for menicon Z night orthokeratology contact lenses. 2017 26-07-2017. Contract No.: QA076-3.
64. Wittich CM, Burkle CM, Lanier WL. Ten common questions (and their answers) about off-label drug use. *Mayo Clin Proc.* 2012;87(10):982-90.



65. Aronson JK, Ferner RE. Unlicensed and off-label uses of medicines: definitions and clarification of terminology. *Br J Clin Pharmacol.* 2017.
66. Riley JB, Jr., Basilius PA. Physicians' liability for off-label prescriptions. *Nephrol News Issues.* 2007;21(7):43-4, 6-7.
67. Wilkes M, Johns M. Informed consent and shared decision-making: a requirement to disclose to patients off-label prescriptions. *PLoS Med.* 2008;5(11):e223.
68. Lenk C, Koch P, Zappel H, Wiesemann C. Off-label, off-limits? Parental awareness and attitudes towards off-label use in paediatrics. *Eur J Pediatr.* 2009;168(12):1473-8.
69. Lenk C, Duttge G. Ethical and legal framework and regulation for off-label use: European perspective. *Ther Clin Risk Manag.* 2014;10:537-46.
70. Weda M, Hoebert, J., Vervloet, M., Moltó Puigmarti, C., Damen, N., Marchange, S., Langedijk, J., Lisman, J., van Dijk, L. Study on off-label use of medicinal products in the European Union. 2017.