When a surgeon is choosing options for patients with presbyopia, there are a number of factors to consider. Kendall Donaldson, MD, Bascom Palmer Eye Institute, Plantation, Florida; Audrey Talley Rostov, MD, Northwest Eye Surgeons, Seattle; and John Berdahl, MD, Vance Thompson Vision, Sioux Falls, South Dakota, weighed in on how they use presbyopia-correcting IOLs and offered pearls, things to avoid, and tips for which patients may be best to receive these implants.

**Pearls for success**

Dr. Donaldson’s first pearl was to start with the perfect candidate for early cases when introducing any new technology or technique into your practice. “The perfect candidate would be a patient who has reasonable expectations and is highly motivated to increase his or her spectacle independence,” she said. It’s also important to take into account personality and lifestyle.

Second, ruling out other pathology is key. Patients should be screened for any comitant disease, Dr. Donaldson said, such as ocular surface disease, macular pathology, or irregular corneal astigmatism.

Dr. Donaldson’s third pearl was to under promise and over deliver, and be honest, she added. “Don’t be afraid to discuss potential adverse effects,” she said. “Always remember that a missed (or unmentioned) preoperative condition is considered a ‘surgical complication’ or ‘side effect’ of the surgery.”

Dr. Berdahl said that if he was giving advice to someone just starting with presbyopia-correcting IOLs, he would tell them to “start with a plan to finish.” There will be a percentage of patients who have residual refractive error or dryness that the surgeon will have to treat in order for them to get to a satisfied spot, he said. If you start with the idea that you will need to do an enhancement on some of these patients or rehab the ocular surface, it makes it better for both the patient and surgeon so they are prepared for it to be a 2-step process: lens and then enhancement.

Dr. Berdahl’s other recommendation was to speak very frankly with patients. “Tell them exactly what you would want to know if you were the patient.” He tells patients that the hope is for increased flexibility in vision with the tradeoff of some quality. This means patients would need glasses less, but there may be some situations where their vision isn’t perfect—such as with visually intense activities like driving at night—because there could be rings around light.

Dr. Talley Rostov said that one important key for success is to become familiar with the technology’s benefits and limitations. It’s important to be able to communicate this information to the patient, she said.

Gauging patient expectations is important. Educating the patient beforehand may help with this, Dr. Talley Rostov said. Managing astigmatism helps in the overall success.

**What to avoid**

Two of the most important things to avoid, Dr. Berdahl said, are putting a presbyopic IOL in an eye that doesn’t have the anatomy for it and putting it in a patient who doesn’t have the psychology for it.

Dr. Donaldson said to avoid unrealistic expectations and highly demanding personalities. In addition, she said to avoid confounding pathology, like ocular surface disease, irregular astigmatism, and macular pathology. Avoid the temptation to perform a clear lens extraction in early cases until you are comfortable using these lenses during routine, uncomplicated cataract surgery, Dr. Donaldson said. “As you gain experience, you can broaden your range of potential candidates to more challenging situations.”

**When presbyopia-correcting IOLs should not be used**

Occasionally, patients will present with fixed ideas and expectations for their surgery, Dr. Donaldson said. “They often present with some degree of knowledge of current technology including femtosecond lasers and premium IOLs,” she said. “Many of these patients are on the younger side and possibly even interested in clear lens extraction for increased spectacle independence.”

“It is our job as physicians to screen patients who may not be good candidates despite their intense desire to be free of glasses,” she said. The most common reason for this situation is uncontrolled or incompletely treated ocular surface disease (OSD), Dr. Donaldson added. “Some of these patients have undergone prior LASIK and blepharoplasty and are very aesthetically oriented, hence their desire for increased spectacle independence,” she said. “We need to explain any OSD and treat preoperatively, repeating measurements after treatment and re-evaluating the ocular surface to ensure a successful outcome.”

Physicians can’t let patients control the final decision if another option may be more appropriate, Dr. Donaldson said. “We have to be able to ‘just say no’ if we feel this technology might not provide the best visual quality despite their primary goal of spectacle independence.”

Dr. Talley Rostov said that patient selection becomes important in knowing which patients to avoid when using the technology. She finds that older patients may be harder to educate in terms of the amount of recovery time it will take before they are seeing better. Patients who have had previous refractive surgery may have unrealistic expectations and may expect to see the way they did after laser vision correction.

A careful look at the topography is necessary, she said. Additionally, Dr. Talley Rostov said a previous RK is a contraindication for multifocal lenses because the surgeon doesn’t want to put a multifocal lens in a patient who has a multifocal cornea.

Dr. Talley Rostov added that using intraoperative aberrometry may be helpful with a presbyopia-correcting IOL in a patient who has had previous refractive surgery because it can help ensure accuracy.

Dr. Berdahl said that he has had to do an IOL exchange when using...
presbyopia-correcting IOLs a few times. This was because the patient was unable to adjust to the quality of vision with this type of IOL. Dr. Berdahl said it’s important to have an exit strategy that you should discuss with the patient.

Managing patient expectations
In addition to under promising and over delivering, Dr. Donaldson said it’s important to take the time to understand what patients would like to achieve from surgery and make sure that their preconceived idea is consistent with their potential outcome.

“Know their goals for their vision,” she said. This includes knowing the needs of patients’ occupations and what hobbies they have that might have their own set of visual demands.

“Watch out for myopic patients as they have higher expectations for their near vision,” Dr. Donaldson said. “This needs to be discussed preop so they understand that their near point may potentially change.”

Perfect candidate
“There’s no perfect candidate,” Dr. Berdahl said. “But the vast majority of people are good candidates.” In his experience, patients are happy with the results when the options are explained to them clearly, when they understand the value and the cost, and when they trust that the surgeon will do what’s in their best interest.

Patients with reasonable expectations who are highly motivated to increase spectacle independence are the best candidates, Dr. Donaldson said. “They should have a healthy eye with solely the presence of a cataract and no other confounding pathology,” she said. “A patient who has a high degree of dependency on glasses preoperatively is much easier to please as compared to a patient with a lesser degree of preop spectacle dependence.”

Editors’ note: Dr. Berdahl has financial interests with Abbott Medical Optics (Abbott Park, Illinois), Alcon (Fort Worth, Texas), Bausch + Lomb (Bridgewater, New Jersey), and Calhoun Vision (Pasadena, California). Dr. Talley Rostov has financial interests with Bausch + Lomb. Dr. Donaldson has financial interests with Alcon and Abbott Medical Optics.

Contact information
Berdahl: john.berdahl@vancethompsonvision.com
Donaldson: kdonaldson@med.miami.edu
Talley Rostov: ATalleyRostov@mweyes.com

Limbal relaxing incisions created with the femtosecond laser according to surgeon nomogram
Source (all): Kendall Donaldson, MD