Helping Unhappy Premium Lens Patients

It is critical to your practice's success that you properly and assertively deal with patients who are dissatisfied with their presbyopia-correcting lenses.

BY JOHNNY L. GAYTON, MD, FSEE

Premium lenses have made a huge impact on both cataract and refractive surgery. Assertively addressing the postoperative concerns of patients unhappy with their presbyopia-correcting lenses is important to a practice's success. The process is challenging, however, because many of these individuals expected to have perfect or nearly perfect vision after surgery. I have many techniques for quieting their discontent.

DRY EYES

Excellent vision starts with a healthy tear film. Any disruption of the ocular surface can negatively affect preoperative measurements and thus surgery and its results. Postoperative dry eye disease decreases contrast sensitivity, blurs vision, and can cause glare and halos.

I prescribe artificial tears postoperatively for all patients undergoing laser eye surgery and/or IOL implantation. At night, I have them use fluorometholone eye ointment, which is a low-potency steroid. I also recommend the use of nutritional supplements, such as omega-3 fatty acids. Finally, I encourage patients to make environmental changes, especially avoiding tobacco smoke and circulating air from cars' air conditioning systems, ceiling fans, etc.

CYSTOID MACULAR EDEMA

With a late onset of 4 to 6 weeks postoperatively, cystoid macular edema (CME) is the most frequent cause of visual decline following uncomplicated cataract surgery.[1] The disease occurs in an estimated 12% of low-risk cataract cases.[2] The complication is due in part to a prostaglandin-mediated breach of the blood-retinal barrier.[3]

Although angiographic CME may not be associated with a significant loss of Snellen visual acuity, it can induce some astigmatism and hyperopia despite a BCVA of 20/20. Patients with clinical CME experience leaking vessels and a visual acuity of 20/40 or worse. Today's definition of clinical CME is becoming stricter (20/25 or worse), however, due to patients' heightened expectations and premium IOLs. Even a small amount of CME results in a decrease in contrast sensitivity. Because multifocal lens technology decreases contrast by dividing light, a small amount of CME can result in a very unhappy patient.

In my opinion, there is no excuse for ophthalmologists not to use NSAIDs prophylactically in patients to prevent CME, especially with all the drugs that are currently available. Dr. Michael Raizman's pioneering study clearly demonstrated the benefits of NSAID prophylaxis in preventing CME.[4] The concurrent use of NSAIDs helps to achieve control of postoperative inflammation faster than steroids alone. The rapid and permanent control of inflammation is critical to decreasing the incidence of postoperative CME. Although all of the NSAIDs are effective, I personally prefer bromfenac. In the phase 3 trials submitted to the FDA, bromfenac controlled inflammation quickly and effectively.[5] Due to the drop's rapid penetration of the cornea and other ocular tissues and strong affinity to the COX-2 enzyme, it only has to be used one to two times per day. The infrequency of dosing improves patients' compliance, especially when you want them to use it for 6 weeks or longer. I use the NSAID for 6 weeks in low-risk patients, but in diabetics and other higher-risk patients, I use the NSAID for at least 8 weeks.

ASTIGMATISM

Limbal Relaxing Incisions

Patients with residual ametropia after surgery with premium IOLs can have a low tolerance for blurry distance vision. Even slight residual astigmatism can markedly decrease the effectiveness of multifocal lenses by further reducing contrast sensitivity.

My colleagues and I conducted a study in which we

combined the AcrySof Restor IOL (Alcon Laboratories, Inc., Fort Worth, TX) with limbal relaxing incisions (LRIs) in 14 eyes of 10 patients with refractive cylinder ranging from 0.50 to 2.25 D. After surgery, 10 eyes had slightly less cylinder, two eyes had not changed, and two had experienced an increase of 0.25 D. The two patients that had an increase in cylinder had lenticular cylinder that was neutralizing corneal cylinder. If LRIs had not been used, the astigmatism would have increased even more. I have performed LRIs for many years, and I always tell patients that the procedure is meant to reduce astigmatism but not eliminate it. LRIs are not as potent or as predictable as laser vision correction, but they are a useful tool in managing small-to-moderate amounts of astigmatism.

Surface Ablation

Unless the patient only has a small amount of astigmatism with a nearly plano spherical equivalent, I perform surface laser vision correction. I prefer surface ablation to LASIK, because the latter procedure is more likely to cause dry eye due to the corneal flap, especially immediately postoperatively. Also, with surface ablation, surgeons can perform an enhancement surgery earlier without having to make a preoperative flap, because a suction ring does not have to be applied to the eye.

For surface laser vision correction, I plan for myopia when calculating IOL power (eg, if a patient has 2.00 D of cylinder before phacoemulsification, my desired pre-laser refraction is plano to -1.00 D with 2.00 D of minus cylinder). Of course, if the patient has had previous RK and has a very flat cornea, I then prefer to steepen the cornea with a hyperopic ablation. I make sure that the patient understands that myopia after phacoemulsification is temporary (ie, his uncorrected distance visual acuity is supposed to be blurry in order to maximize his final vision). I offer an inventory of loaner glasses to help patients "survive" the 6-week period before their enhancement procedure. I will consider an Nd:YAG laser treatment prior to performing surface ablation.

In my experience, patients who undergo LASEK after receiving the AcrySof Restor IOL achieve a marked improvement in their astigmatism. For example, I performed laser vision correction on a 42-year-old female who had a history of lensectomy with the AcrySof Restor IOL in both eyes. I targeted myopia because I was going to treat her astigmatism later with surface ablation—1.50 D of cylinder OD and 2.25 D OS. The patient achieved an improvement in her uncorrected distance and near acuity (from uncorrected distance vision of 20/40 OD and 20/60 OS and uncorrected near vision of 20/30 OD and 20/50 OS to 20/20 near and distance in both eyes).

TORIC LENSES

Toric lenses are an excellent method of addressing corneal astigmatism, especially in patients who should not have additional corneal surgery and in those with coexisting cataract and astigmatism. These lenses are not contraindicated in patients with conditions that decrease their contrast sensitivity, because the IOLs improve contrast. These lenses not only accurately correct astigmatism, but they are also very forgiving. Even if they are implanted 15° off axis, patients achieve 50% correction of their astigmatism. In my experience with my first 100 eyes using the AcrySof Toric lens (Alcon Laboratories, Inc.), the patients' average preoperative cylinder was 1.78 D and average postoperative cylinder was 0.26 D. In eyes that have more than 2.00 D of astigmatism, I will combine technologies (eg, toric IOL and LRIs or toric lens and laser vision correction).

Caring for unhappy premium lens patients is not only critical to your success it can be very rewarding. I have cared for patients that others and I have implanted. Converting them to happy patients frequently results in their becoming referral sources for my practice. The two most important things that I can share seem like platitudes, but they are critical to caring for patients. The first is that patients do not care how much you know until they know how much you care. A caring attitude goes a long way in calming an anxious or unhappy patient. The second is a remark from one of my ophthalmic heroes, J. Lawton Smith, MD, who said, "listen to your patient and they will tell you what is wrong." Listening will usually enable you to tell whether the patient has a medical problem, or if he simply needs more education about how to use the lens. It will also demonstrate that you care. Follow these principles, and you should have a very rewarding premium lens practice. ■

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