

Selecting Patients for Presbyopic Correction

A three-step process can help you identify the best surgical candidates.

BY JOHN F. DOANE, MD

If there were one mantra for implanting presbyopia-correcting IOLs, it would be *proper patient selection*. These three words do not begin to describe the intricacies of the process, however. This article outlines an approach to patient selection that may help you navigate the emerging field of presbyopic correction.

STAGE 1: IDENTIFY INTERESTED PATIENTS

The initial hurdle to identifying the best candidates for presbyopia-correcting IOLs is determining if there is sufficient interest in this option among your patients. I begin by dividing my patients into two groups—those best suited for refractive lens exchange versus those with cataracts.

Presbyopic patients who have a great desire to forego their spectacles for most, if not all, of their daily tasks and who cannot tolerate monovision are not good candidates for standard LASIK correction with distance targeted in each eye, but they are excellent candidates for presbyopia-correcting IOLs. A third option for this patient group that will likely become available in the future are phakic multifocal implants, but these are not currently available in the US.

Determining if cataract patients will benefit from presbyopia-correcting IOLs is more complicated and requires asking these individuals several questions, particularly because of the Centers for Medicare & Medicaid Services' Ruling Number 05-01.¹ Now that patients can specifically request the implantation of presbyopia-correcting versus conventional IOLs, the typical cataract

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consultation has expanded to include a discussion of this new corrective option. If you skip this step, you may incur resentment from patients who find out postoperatively that they could have received a presbyopia-correcting IOL.

Fortunately, posing a series of yes/no questions to cataract patients can help you differentiate between appropriate and unsuitable candidates for presbyopia-correcting IOLs. I always ask two questions: (1) After you have surgery, would you be interested in not wearing eyeglasses for most of your activities? and (2) Would you be interested in paying out of pocket if this outcome were possible?

If patients say "yes" to both questions, I feel confident proceeding to stage 2 of the selection process. If they say "no," I will probably limit my discussion to non-presbyopia-correcting IOLs.

STAGE 2: FILL IN THE DETAILS

Once patients express interest in and make a preliminary financial commitment to presbyopia-correcting IOLs, I concentrate on selecting a lens that will meet their

individual needs. At this time, I discuss the same points with cataract and refractive patients, although I sometimes provide the latter with more specific information.

I always ask patients about their occupations, because someone who drives a truck at night has different visual needs than someone who works in an office reading documents and using a computer. Resources such as the Dell Index (available at <http://www.crstoday.com/Pages/DellIndex.doc>) can help you determine the visual ranges for which patients want spectacle independence and how well they will tolerate dysphotopsia.

Patients whose work requires low light levels or nighttime activities are usually adverse to dysphotopsias and will probably be happiest with an accommodating IOL. Because hobbies such as archery and marksmanship require excellent visual quality, individuals who enjoy these activities can benefit from the maximal contrast sensitivity offered by accommodating lenses. Finally, patients who read a lot of small print can probably achieve spectacle independence with a multifocal lens or could be treated with an accommodating IOL targeting plano in one eye and -0.50 to -0.75D in the other.

Some patients may achieve satisfactory vision at all visual points with minimal dysphotopsia when each of their eyes receives a different multifocal IOL or a combination of multifocal and accommodating IOLs. Determining which patients are strong candidates for mixed IOLs requires additional probing by you and your staff. In many cases, you can get the extra information you need by presenting several alternative scenarios designed to determine the patients' preferences and by using your previous surgical experience to select the IOLs that will meet their needs. For example, a patient who has functioned well despite seeing haloes at night with his spectacles and contact lenses would be a good candidate for multifocal IOLs, unlike a patient who is actively trying to avoid seeing haloes at night.

Of all the patients who can benefit from presbyopia-correcting IOLs, plano and low-myopic presbyopes may be the most difficult to please. Unlike hyperopic presbyopes with cataracts whose preoperative uncorrected vision is very poor in all three focal point ranges, plano or low-myopic presbyopes with clear lenses only have deficiencies at near or distance, respectively. To satisfy these subgroups, surgeons not only must be at the top of their game, but they also must deliver nearly flawless visual function. If these patients do not obtain excellent outcomes at near, intermediate distance, and distance, they may consider their outcome a failure. Therefore, it may be best to avoid refractive lens exchange in these individuals until you can lower their

expectations or deliver results that will make them happy.

STAGE 3: SET PATIENTS' EXPECTATIONS

For many patients, the last stage in the process of proper selection is the most difficult. At this point, they must develop realistic expectations or at least acknowledge that they may need to undergo additional procedures to achieve the great visual outcomes they want. Even if the IOLs' implantation is executed flawlessly from a technological standpoint, some patients will perceive the surgery as a failure if they need additional procedures. It is critical for patients to understand that, if their postoperative vision is slightly "off," they can still achieve their visual goals with laser-based or other corneal refractive procedures.

Patients who are not willing to recognize they might need additional surgery should be discouraged from receiving presbyopia-correcting IOLs. They should also be excluded if they have forme fruste keratoconus or other corneal pathologies that could disqualify them for additional refractive procedures, depending on the surgeon's comfort level for treating patients with these corneal diagnoses.

ACHIEVING SUCCESSFUL OUTCOMES

Ultimately, proper patient selection depends on planning. First, you should approach the procedure with foresight, which will give you the flexibility to implement contingency plans as necessary. Second, educating your patients preoperatively establishes a strong relationship and increases the chances of both parties' achieving a satisfactory outcome. If the same information is presented postoperatively, patients are less likely to receive it with open ears.

I hope the advice presented in this article clarifies the meaning of *proper* in the phrase *proper patient selection*, and helps you successfully identify the candidates who can benefit from presbyopia-correcting IOLs. ■

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1. Centers for Medicare & Medicaid Services. CMS Ruling Number 05-01. May 3, 2005. Available at: <http://www.cms.hhs.gov/Rulings/downloads/CMSR0501.pdf>. Accessed November 30, 2006.