

Thoughts on 2010

Last year was an outstanding one for ophthalmology. I spent time over the holidays thinking of the best of 2010. My thoughts were guided by Gillian McDermott's excellent article on the subject that appeared in *Cataract & Refractive Surgery Today's* January 2011 edition.¹ This valuable survey shares top ophthalmologists' impressions of the best clinical pearls, published articles, software, technical innovations, and new technologies.

So, where did we come up short? Presbyopia. Other than a tip from Bruce Wallace, MD, about educational software for presbyopia-correcting IOLs, none of us had much to say on this subject. Presbyopia is the most common problem for the largest number of our patients. Although we have good options (LASIK and PRK) for patients under 40 and advanced IOLs for individuals with cataracts over the age of 65, we have nothing for that middle group. We need a "bridge" procedure to help these patients and keep them in our practices between LASIK and cataract surgery.

Where did we excel? I agree with Eric Donnenfeld, MD, that there was "nothing as exciting in 2010 as the development and approval of femtosecond-assisted cataract surgery."¹ What excites me are the benefits the technology offers to our patients. Safety will be enhanced by reduced phaco time and power, less time in the eye, and finer, more elegant incisions, among other innovations. Precision may be increased by an exactly sized, shaped, and positioned capsulotomy that will better control the IOL's final resting place as well as by exact incisions and standardized, quantifiable astigmatic keratomies. Femtosecond lasers could make possible many other technologies, including polymer IOLs that can be injected through a tiny capsulotomy.

Laser cataract surgery "has stirred the most heated and heartfelt discussions on the ASCRS Internet Forum seen since its inception 6 years ago," J. E. "Jay"

McDonald II, MD, has commented.¹ Most of that debate has not been about the capabilities of the technology but its real-world practicality. Will patients seek it out? Is it economical? Who will pay for it? I have a unique perspective here. I have been performing laser cataract surgery commercially in Houston for nearly a year now on all of our practice's premium IOL patients and most of our other cataract patients. Since LenSx Lasers Inc. (Aliso Viejo, CA) delivered the platform to us in February 2010, we have not been part of an FDA trial or subject to other investigational device restrictions. The laser already had 510(k) clearance for anterior capsulotomy when we received it, and clearance for incisions and lens fragmentation quickly followed. In my experience, patients easily understand and prefer "laser" cataract sur-

gery, and they seek it out. Yes, there are added costs, but because this advanced technology is not covered by Medicare, patients can assume these costs if they so choose. In other words, patients can elect to pay for what they decide is better care, safety, and efficiency.

On January 1, the first baby boomers turned 65 and entered Medicare, with an estimated 10,000 hitting that milestone each day now. The US population over the age of 65 is projected to double in 7 years. Even if residency programs begin growing today, it will take about 7 years for the first added eye surgeon to hit the streets. In the meantime, most of us will form our practices around these educated, demanding, financially secure baby boomers. I believe the development and availability of laser cataract surgery are right on time. ■



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1. McDermott G. The best of 2010. *Cataract & Refractive Surgery Today*. January 2011;11(1):44-49.