

# Jumping on the Premium IOL Bandwagon

Are you ready to make the transition?

BY JOHN F. DOANE, MD

Anyone contemplating providing premium lenses in the form of presbyopia-correcting IOLs or toric IOLs should be able to answer two questions:

- Are you satisfied with the outcomes data of the specific premium IOL you are considering?
- Will the lens and you deliver the results that your patients expect?

If you answered no to these questions, you need not read further. If you answered yes, you need to answer the following: Is my practice and am I prepared to accept the inherent challenges of premium IOL technology and the types of patients who are drawn to its benefits?

I hope that this article will help you and your team to understand better what is involved in meeting or exceeding patients' preoperative expectations and whether it is feasible for your practice to begin offering premium lenses.

## THE CHALLENGE

Both conceptually and practically, obtaining excellent unaided distance, intermediate, and near vision with presbyopia-correcting IOLs is significantly more challenging than achieving excellent unaided distance vision with LASIK. For the past decade, I have felt that presbyopia-correcting IOLs require intensive work because of the possible variances in postoperative outcomes. With LASIK, if the surgeon achieves emmetropic distance vision for prepresbyopic patients, the crystalline lens will facilitate

intermediate and near focal points through natural accommodation. A suitable result can be achieved if the majority of eyes are within  $\pm 0.50$  D (1.00 D range) of the target. In essence, presbyopia-correcting IOLs require a plano result. The acceptable postoperative refraction is within a 0.25 D range. With accommodating IOLs, the ideal postoperative refraction is plano to  $-0.25$  D. With diffractive multifocal IOLs, the most desirable endpoint is plano to  $+0.25$  D. Upon achieving these results, you and your patient depend on the IOL to provide the intermediate and near focal points that the patient is accustomed to and/or finds acceptable.

In other words, LASIK has one variable—hitting the refractive target. Presbyopia-correcting IOLs have three variables: (1) hitting the refractive target, (2) the IOL's provision of intermediate focal points, and (3) the IOL's provision of near focal points.

If you consider the variables in terms of their level of difficulty, presbyopia-correcting IOLs are nine times harder than LASIK. LASIK may be involved, however, in about 25% of cases. Are they typical LASIK odds? No, because of the usual correction performed with LASIK after IOL implantation is for 0.50 D spherical equivalent, therefore, the odds of hitting that target are much higher than with LASIK on virgin eyes.

## DETERMINING YOUR READINESS

In order to figure out whether you and your practice are ready to begin offering premium IOL technology to your patients, I suggest carefully answering each of the following questions:

- Are you willing to change what you are doing today?
- Are your technicians willing to change?
- Is your staff prepared to meet the more demanding “refractive mindset” of patients seeking and receiving presbyopia-correcting IOLs?
- Is your billing office equipped to handle credit applications and explain different options for payment?
- Are you geared up to have heart-to-heart discussions with each patient preoperatively about what you and the technologies can and cannot provide?
- Are you ready to ask patients to spend their hard-earned cash (typically \$2,000 to 3,000 per eye for a presbyopia-correcting IOL upgrade of cataract surgery)?
- Are you prepared to become exceedingly precise and accurate in axial length measurement and keratometric values?
- Are you ready to become better at creating a continuous curvilinear capsulorhexis, performing complication-free nuclear removal, cortical extraction, and capsular polishing?
- Do you have a plan to handle vitreous loss in an eye scheduled to receive a premium IOL?
- Did you ever perform RK or laser vision correction, and did you thoroughly enjoy working with demanding patients?
- Will you be able to perform refractive laser enhancements on approximately 20% to 25% of eyes to achieve the refractive target?
- Are you willing and able to treat 30% of your patients with limbal relaxing incisions and willing to perform IOL exchanges or piggyback IOLs in the sulcus?

If you enthusiastically answered yes to all of these questions, you can confidently pursue the presbyopia-correcting IOL delivery channel. If you hesitated or answered no to many of the questions, I believe you will find offering premium IOLs frustrating, and I would suggest that you hold off until your outlook changes dramatically. Surgeons must share all of the highs and lows that their patients experience until they achieve excellent unaided vision at all focal points. Ophthalmologists will have to deal with patients who feel as if they did not achieve what they expected.

## CLOSING THOUGHTS

I am an enthusiastic provider of premium IOLs. I am thrilled to help patients become free of their spectacles for all or most tasks. The work involved in this process, from preoperative screening to postoperative enhancements, is intense. To perform well, surgeons must have the desire and commitment to leave no stone unturned to help patients attain their desired outcome.

The devices presently available are very good but will not achieve perfect distance, intermediate, and near vision in every person. It is imperative to ensure that patients have realistic expectations for the procedure. The growth of this surgical category requires preoperative counseling, the highest level of biometric accuracy, flawless intraoperative technique, and astute postoperative management of patients. ■

*John F. Doane, MD, is a clinical assistant professor with the Department of Ophthalmology at the Kansas University Medical Center in Kansas City, and he is in private practice with Discover Vision Centers in Kansas City, Missouri. Dr. Doane may be reached at (816) 478-1230; jdoane@discovervision.com.*

