

# ADVANCES IN IMPLANTATION OVER THE YEARS

Changes in technique have a direct correlation with decreases in a corneal inlay's removal rate.

BY MINORU TOMITA, MD, PhD



Having implanted more than 13,000 Kamra corneal inlays (AcuFocus) in the past 5 years, my vast experience with this technology accounts for about 80% of all international cases. Given these facts, it is safe to say that I have helped to refine not only the technique for implantation but also the technology itself. With such a vested

interest in the Kamra corneal inlay, I was excited to hear of its recent approval by the FDA. In my opinion, the Kamra affords patients improvements in near and intermediate visual acuity, better contrast sensitivity than an accommodating or diffractive multifocal IOL,<sup>1</sup> and a minimal compromise of distance vision.

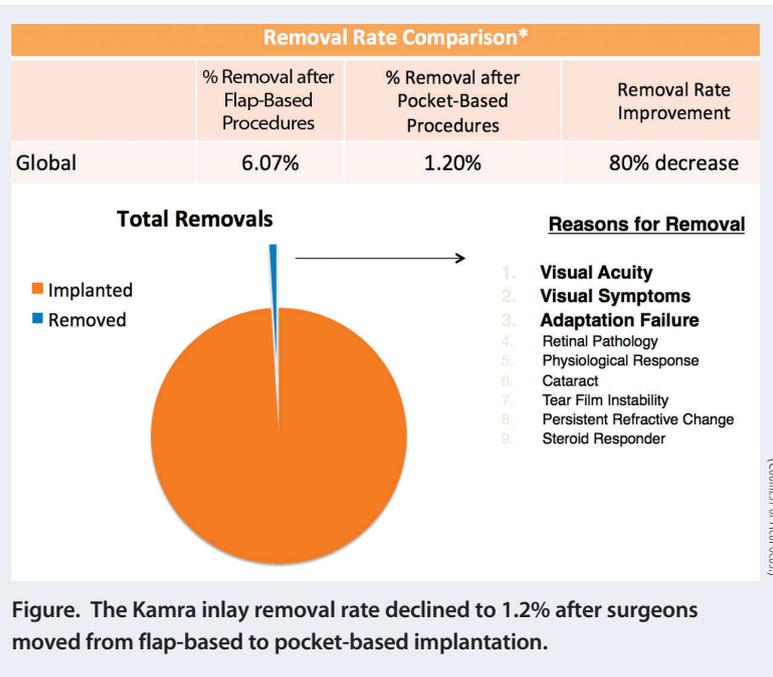
## METHODS OF IMPLANTATION

I began using the Kamra during my time as the executive medical director at Shinagawa LASIK Center in Tokyo, and I continue to use the device now that I am in private practice at the Minoru Tomita Eye Clinic Ginza. In my early experience, the inlay was implanted using a technique that the company called *combined LASIK-Kamra* (CLK), whereby the inlay was implanted simultaneously with LASIK under a 200- $\mu$ m lamellar flap.

CLK was subsequently abandoned, because operating under a thick flap had obvious disadvantages for patients (induction of dry eye, slow visual recovery) and surgeons (difficulty centering the inlay for implantation, extensive postoperative management). Furthermore, AcuFocus global registry data showed that the incidence of a wound-healing response was 17% with the CLK technique (data on file with the company), and my explantation rate in nearly 4,000 cases was approximately 5%. I found that the reasons for removal included patients' dissatisfaction with their vision and/or failure to adapt to their vision with the inlay.

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Today, the Kamra inlay is implanted into a lamellar pocket at or deeper than 200  $\mu$ m, and in 90% of cases, the device is combined with LASIK using a dual-interface technique. In this approach, the excimer laser correction is performed under a thin flap, and the inlay is implanted at least 100  $\mu$ m below the LASIK interface, inside a corneal pocket. The pocket is created with a femtosecond laser





## AT A GLANCE

- Initially, corneal inlay implantation was performed simultaneously with LASIK under a 200- $\mu$ m lamellar flap. The combined LASIK-Kamra technique was subsequently abandoned, as operating under a thick flap proved to have obvious disadvantages for patients and surgeons.
- Today, the inlay is implanted into a lamellar pocket at or deeper than 200  $\mu$ m and is typically combined with LASIK using a dual-interface technique.
- The advantages of a dual-interface technique include the ability to fine-tune patients' refractions and to capitalize on the advantages of thin-flap LASIK and deep-pocket corneal inlay implantation.

using a spot/line separation of 6 X 6 (or the equivalent), because my fellow investigators and I have concluded that it produces smoother beds and better postoperative outcomes than other spot/line separations.

I have implanted about 9,000 corneal inlays with the corneal pocket technique, and my overall explantation rate is somewhere between 1% and 2% within 3 years of implantation. In a recent study of 223 eyes undergoing the corneal pocket procedure, the mean near UCVA improved 4 lines, from J8 preoperatively to J2 6 months postoperatively ( $P < .001$ ), and patients' spectacle dependence and satisfaction with spectacle-free reading improved significantly.<sup>2</sup>

The advantages of a dual-interface technique include the ability to fine-tune patients' refractions and to capitalize on the advantages of thin-flap LASIK and deep-pocket corneal inlay implantation. With that said, some patients (4%) still experience an aggressive wound-healing response characterized by stromal thickening over the inlay, central flattening, the development of haze over the inlay annulus, and a hyperopic shift after inlay implantation with a corneal pocket technique. In the vast majority of these patients, however, the wound-healing response can be resolved with steroid therapy.<sup>3</sup> Inlay explantation should be considered if either the eye does not respond to steroids or the wound-healing response rebounds after treatment.

### REMOVAL RATE

As I previously mentioned, my removal rate with the Kamra corneal inlay decreased from 5% with the CLK technique to between 1% and 2% with pocket implantation. This closely reflects data from the AcuFocus global registry (6% with CLK and 1.2% with pocket implantation; Figure). Furthermore, these removal rates are comparable to the

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reversal rate of monovision<sup>4,5</sup> and approach the rate of IOL exchange.<sup>6</sup>

For this reason, and because of the advantages of pocket implantation outlined earlier, the AcuFocus Global Medical Advisory Board now recommends that the Kamra always be implanted in a corneal pocket.

### OVERALL EXPERIENCE

Although a small percentage of patients experience a hyperopic shift postoperatively, in general, presbyopes who are motivated to achieve spectacle independence do well with the Kamra corneal inlay implanted in their nondominant eye. Compared with the other inlays available outside the United States, I believe that the Kamra is the best option for my patients. This is mainly because the Kamra is the only technology that can maintain a distance visual acuity of 20/20 and provide patients with near and intermediate visual acuity in the range of J1 to J2 (personal experience). Additionally, surgical complications are rare and have decreased with advances in implantation technique.<sup>7,8</sup> ■

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