HOW I USE CORNEAL INLAYS IN MY CLINIC TODAY

Insufficiently good outcomes in the past changed this physician's approach to patient selection and surgical technique.

BY ARTHUR B. CUMMINGS, MB ChB, FCS(SA), MMed(Ophth), FRCS(Edin)

I have been using the Kamra inlay (AcuFocus) for 4 years. Initially, I followed the company's recommended procedure known as SimLASIK, which involved placing an inlay under a LASIK flap that is 180 to 200 µm thick. Eighty percent of my patients did brilliantly with the implant, but 20% were unhappy with their outcomes. Reduced distance acuity, inadequate reading vision, and glare at night were the most common reasons that I explanted 20% of the Kamra inlays I implanted with the SimLASIK technique. Having 20% of a patient group unhappy does not work in a commercial or private setting, so I stopped implanting the device.

Over time, however, I saw patients who had excellent outcomes with the Kamra and were thrilled with their visual ability. I realized that patients using backlit screens (smartphones, tablets, laptops, personal computers) did particularly well with the inlay. The best refractive target was around -0.50 to -1.00 D, and for those in whom the Kamra worked, it worked very well. The inlay is not for the patient who requires 100% freedom from glasses, because it does not perform well in low light.

MY CURRENT APPROACH

Patient Selection

I have started using the Kamra selectively again in patients who have realistic expectations and know that it will not work in the dark. My colleagues and I call the vision that the Kamra provides "reading on the go," and we only implant the inlay in patients who rate vision with a +1.00 D loose lens test in front of their nondominant eye as acceptable or better. We no longer use the SimLASIK approach. Instead, we perform a post-LASIK pocket technique in two stages or PLK2. We perform LASIK targeting -0.75 D, create the inlay pocket, and then implant the device 4 to 6 weeks later.

Pocket Technique

I have very little experience with this technique at present, but my early impression is that it works better than SimLASIK. Several of my colleagues have had the same experience with PLK2 compared to SimLASIK.

My advice is to select the right patients and to start slowly instead of treating every presbyope who comes in for a surgical consultation. Once familiar with the inlay's performance in his or her own hands and satisfied with the outcomes, a surgeon can start building the numbers.

CONCLUSION

The Kamra inlay is one of the solutions that I offer alongside monovision (the most popular) and the Raindrop Near Vision Inlay (ReVision Optics; not available in the United States). For the patient who can tolerate monovision in a contact lens trial, I recommend monovision. If he or she cannot tolerate monovision and is emmetropic or slightly hyperopic (up to +1.25 D), then I implant the Raindrop inlay. This approach with the Raindrop is achieving a high level of satisfaction among patients at this early stage of my experience. If the patient is a low myope, then I typically offer the Kamra inlay and implant it using the pocket technique. ■

AT A GLANCE

- Dr. Cummings implants the Kamra inlay in low myopes with the pocket technique.
- He finds that the Kamra inlay does not work well in low light conditions.
- For the author, the explantation rate was 20% with the SimLASIK method.
- To date, the pocket technique has resulted in better outcomes for Dr. Cummings' patients.

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