



# NEW LENS EUPHORIA

In 2003, I was fortunate enough to be a part of a small team responsible for putting together educational programs for physicians implanting a new generation of presbyopia-correcting IOLs. The stakes were high: For the first time, surgeons would be charging patients substantial fees for implanting a lens. At the time, patients were unaccustomed to the notion that cataract surgery was not free, or at least 80% covered by insurance. We knew that we needed to tread lightly and set expectations realistically.

New surgical challenges awaited the early adopters of presbyopia-correcting lenses, and, to build surgical and clinical confidence, we wanted to stack the deck heavily in favor of favorable outcomes. We emphasized that, for their first cases, surgeons should select candidates for whom the probability of success was very high. Typically this meant selecting patients with moderate hyperopia and a significant cataract. For this patient group, even an IOL of 1980s vintage would probably have resulted in a happy patient. My colleagues and I were shocked when one surgeon revealed that he had accumulated a waiting list of plano presbyopes seeking refractive lens exchange, and he intended to use them as his first dozen or so cases. We politely suggested that these would not be ideal early candidates.

## A CURIOUS PHENOMENON

Today, the dominant presbyopia-correcting IOLs in the United States are low-add multifocal and extended depth of focus IOLs. These lenses are substantially better than early-generation multifocals in terms of photic phenomena and visual performance, but, in my experience, all of these lenses are subject to a curious phenomenon I will call *new lens euphoria* (NLE).

NLE behaves much like an infectious disease, affecting surgeons, optometrists, staff, and patients. NLE is triggered when the belief exists—true or not—that a new lens will avoid the problems of previous lenses. In the early stages of NLE, surgeons limit their use of the new lens to easy candidates who would probably do well with any IOL. Good results and happy patients ensue, resulting in an enthusiastic embrace of the lens by members of the practice. This enthusiasm infects subsequent patients, who are strongly influenced by the practice's favorable perception of the

new lens. Slowly, surgeons become a bit bolder and begin using the new lens in more challenging cases.

Patient complaints regarding photic phenomena in the early postoperative period are often mixed in with a constellation of other signs and symptoms commonly seen with any IOL. Some patients mentioning these complaints are reassured that the issues will subside, and the overwhelming majority do. Although there are exceptions, in many cases it is not clear that patient complaints are mainly IOL-related until weeks after the surgery. Even then, additional reassurance and observation is typical since many of the conditions bothering these patients will continue to improve. The rare patient who graduates to a discussion of possible IOL exchange is often months postoperative.

NLE continues to build steadily during this phase. If the titer of complaints continues to rise, however, the practice's perception of the new lens changes slightly, and patients perceive this change. Surgeons begin to ratchet down their indications for using the new lens, and the outbreak of NLE begins to subside to baseline levels.

## TAKE HEED

The course of NLE was easy to observe with older multifocals, but with newer IOLs it has become a bit tougher to discern. Visual complaints are less noticeable, and surgeons have learned from previous experience to properly counsel patients regarding what to expect postoperatively. While NLE is the most prominent example we encounter, a similar form of euphoria can accompany the introduction of any technology, procedure, or drug. We would all do well to remember that our early experiences with the easiest cases may not translate well to wider use of a new IOL or other technology later on. ■

A handwritten signature in black ink, appearing to read "Steven J. Dell". The signature is stylized and fluid.

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