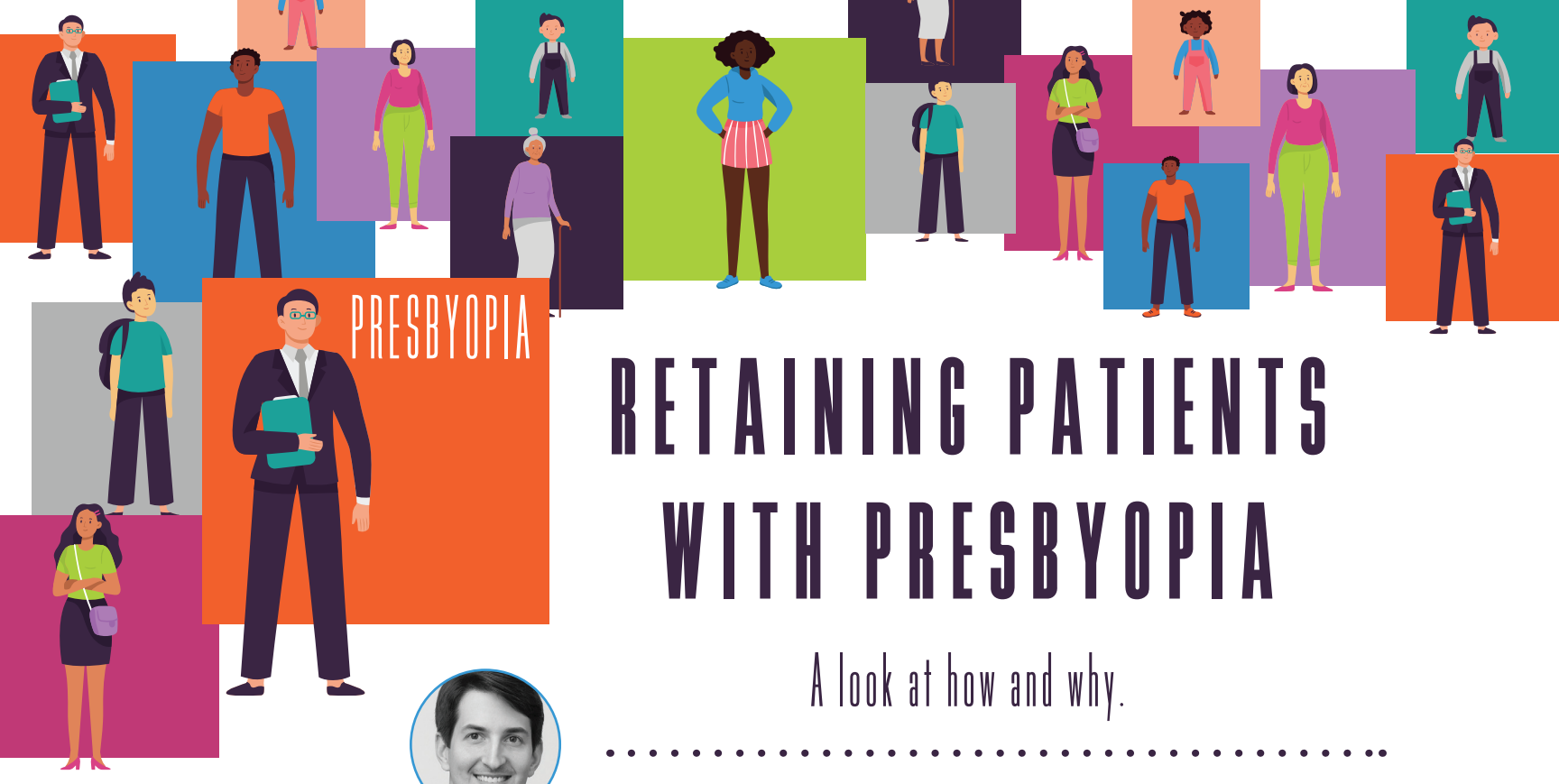

RETAINING PATIENTS WITH PRESBYOPIA

A look at how and why.

O. BENNETT WALTON IV, MD, MBA

In the early days of our practice, Stephen G. Slade, MD, FACS, and Richard Baker, OD, had a conversation about all of the happy LASIK patients they had already treated. The clinic was as busy as it could be. It was a time when a huge backlog of patients, composed predominantly of individuals with myopia—whether they had presbyopia or not—were delighted finally to have an option for vision correction other than spectacles and contact lenses.

The topic of discussion was whether patients should continue returning for routine exams after undergoing LASIK. On the one hand, the visits took up room on the schedule. On the other, the patients would need further surgical care as they aged. Beyond surgery, however, Dr. Baker wanted to grow the optometric part of the practice. At the time, it was hard to imagine how successful modern refractive cataract surgery would become. Keeping those patients in the practice turned out to be highly beneficial for patients and the practice.

Historically, patients with emmetropic presbyopia have been among the hardest for surgeons to make happy. To quote a longtime member of the ophthalmic industry, Andy Corley, "Presbyopia is undefeated." The difficulty of treating presbyopia, however, does not mean that these patients are not important to a practice.

EVALUATE THE PRACTICE

Before assessing the relevance to a practice of retaining patients with presbyopia, it's important to examine the time-oriented nature of that practice. Does it offer longitudinal care for a patient's whole life, one-time specialized surgery, or something in between? These questions can frame the practice's approach to retaining patients with presbyopia.

WHY KEEP THESE PATIENTS?

The desirability of retaining patients with presbyopia is obvious for a longitudinal patient care practice. The benefits for surgically oriented practices are less obvious but include the following reasons.

▸ **Reason No. 1: Continuing education.** Beyond generally recommended surveillance, patients can benefit from continuing education. It is hard for them to recall information on the aging eye from a 10-minute conversation they had with their doctor many years ago. Presbyopia and cataract are difficult concepts for patients to comprehend, let alone remember.

▸ **Reason No. 2: Proper care.** Staying in the practice can give patients access to new technologies as they become available. Patients who develop dry eye and ocular allergies, which tend to worsen over time, can receive care from their doctor instead of purchasing over-the-counter products that may not be what they need. Continued care also allows the provider to bust the pervasive myth that LASIK wears off and avoid having to lure patients back for presbyopia and cataract care.

▸ **Reason No. 3: Reputation management.** It is amazing how many patients cannot recall who performed their life-changing surgery. Maintaining a connection with them is therefore key to growing the reputation of a refractive surgery practice.

THE CHANGING LANDSCAPE OF PRESBYOPIA CORRECTION

Options for mainstream patients with emmetropic presbyopia are lacking but expanding. Individuals

with early presbyopia may benefit from a pharmaceutical approach. At present, the only topical agent available in the United States is Vuity (pilocarpine HCL ophthalmic solution 1.25%, Allergan). Individuals with presbyopia who are interested in IOL surgery may be candidates for a multifocal lens such as the AcrySof IQ PanOptix (Alcon) or Tecnis Synergy (Johnson & Johnson Vision) or an extended depth of focus lens such as the AcrySof IQ Vivity (Alcon) or Tecnis Symfony (Johnson & Johnson Vision). The Light Adjustable Lens (RxSight) can be customized after implantation to create an extended range of vision that the recipient can test before it is locked in.

Allogenic corneal inlays on the horizon may prove to be an even better option for patients with presbyopia.

HOW TO APPROACH VISITS WITH PATIENTS WHO ARE PRESBYOPIC

▶ **Medical examinations.** Eyes are evaluated for health problems such as glaucoma, hypertension, ocular surface disease, and diabetes-related issues.

DIGITAL EXCLUSIVE

For a European perspective on this topic, scan the QR code to read an article by Arthur B. Cummings, MB ChB, FCS(SA), MMed(Ophth), FRCS(Edin)

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▶ **Educational and planning sessions.** The duration of each visit need not be long. It is important to discuss the presence and effects of early cataracts and prevent patients from conflating symptoms caused by separate entities. Explanatory drawings to which patients can later refer may be helpful.

▶ **Opportunities to build trust and the doctor-patient relationship.** Saying, "Well, everything's great. See you in a year," and letting patients depart may leave them feeling like the visit wasn't worth their time. A customized message is a better approach. "Of the three things we're looking at—lens health, ocular surface health, and retinal and optic nerve health—the lens is slowly changing, as expected, but not to the point of needing to be replaced. We know this will continue, and we will be able to replace it with a clear lens when the time comes. If anything with your vision or eye comfort changes before your next appointment, let me know."

The more patients view their eye doctor as an advocate and educator planning their vision journey, the better it is for everyone involved. ■

O. BENNETT WALTON IV, MD, MBA
- Refractive, cataract, and cornea surgeon, Slade & Baker Vision, Houston
- Member, *CRST* Editorial Advisory Board
- drwalton@visiontexas.com
- Financial disclosure: Consultant (Alcon, Allergan/AbbVie, RxSight); Research (Alcon, Johnson & Johnson Vision, RxSight); Speaker (Alcon)

DIGITAL EXCLUSIVE

Refractive Outcomes in Patients With Primary Open-Angle Glaucoma

The potential role of peripheral anterior synechiae.

CHUNGKWON YOO, MD, PHD
- Chief, Department of Ophthalmology, Korea University Anam Hospital, Korea University Medical Center, Seoul, South Korea
- Professor, Department of Ophthalmology, Korea University College of Medicine, Seoul, South Korea
- ckyoomd@korea.ac.kr
- Financial disclosure: None

TAE-EUN LEE, MD, PHD
- Professor, Department of Ophthalmology, Jeonbuk National University Medical School and Hospital, Jeonju, South Korea
- Financial disclosure: None

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- The results of a study conducted by Drs. Yoo and Lee indicated that IOL power calculations can be less accurate in eyes with angle-closure glaucoma (ACG) that have peripheral anterior synechiae (PAS) compared to eyes with ACG that do not have PAS.
- The retrospective, cross-sectional study enrolled 70 patients with primary ACG who underwent cataract surgery.
- The authors concluded that the presence or absence of PAS may influence postoperative refractive outcomes in patients with primary ACG. Because anterior chamber deepening was limited by PAS, a myopic shift could occur.