A Worthwhile *Effort*

This month's cover series focuses on astigmatism management in cataract surgery. I am passionate about the subject because it is an area where we surgeons can greatly improve patients' lives. Educating my peers to reduce the stress they may feel about assessing, planning, and performing toric IOL implantation has been a major part of my career, and this edition of *CRST* is filled with advice from amazing colleagues from around the world.

An optometrist who treated only spherical error with glasses would soon be out of business, yet for a long time it has been acceptable for ophthalmologists to undertreat astigmatism. Financial constraints are one reason for our slow uptake of toric IOLs, and the issue is unavoidable in some situations. I nevertheless hope that, in the future, governments and insurance carriers cover toric IOLs worldwide. Replacing a patient's poor vision due to cataracts with poor vision due to untreated astigmatism that requires them to purchase glasses strikes me as a bad long-term financial decision.

Another common barrier to our adoption of toric IOLs has been uncertainty about how to manage residual astigmatism if it occurs. The articles in this issue describe strategies and tools for minimizing the problem and facilitating decision-making and fixes when it occurs. It is important to appreciate that biometry is performed on a changing liquid surface. We are also attempting to estimate where an IOL will sit within an individual eye and hoping the brain will accept the optical outcome. As this month's contributors explain, the key to success is our attention to detail. Obtaining accurate biometry measurements, using proven IOL formulas, considering customized toric IOL powers, flipping the axis, and creating temporal incisions are individually minor variables but together can improve refractive outcomes.

I am honored to serve as guest medical editor of this edition of *CRST*. If there is one message I hope the cover series conveys, it is that we must change our mindset from *doing* cataract surgery to *performing* a refractive procedure. We can do better than simply replacing an opaque crystalline lens with an artificial one. Aside from removal of the cataract, the procedure is the same as refractive lens exchange. We therefore should have the same aspirations for these patients' postoperative vision. It takes a little more effort, but the effort is worthwhile. ■

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