The Annual ACES/SEE Caribbean Eye Meeting presents hot topics for anterior segment surgeons and healthcare professionals.

Next year's meeting will be held from January 31st to February 3rd, 2025, at the JW Marriott Los Cabos Beach Resort & Spa in San José del Cabo, México. Join Program Chairs William Wiley, MD, and Robert Weinstock, MD, along with other well-known leaders in ophthalmology to discuss important topics in eye care and earn CME/COE credits while connecting, recharging, and elevating your practice in unparalleled tropical splendor. The following summary of a presentation from the recent 2024 meeting provides a taste of the programming at Caribbean Eye. Use the QR code to access the videotaped recording of this presentation and other key talks from the meeting.

REFRACTIVE TOUCH-UP VS IOL EXCHANGE

An algorithm to treat the unhappy cataract patient.

By James D. Lehmann, Jr., MD

Over the years, I have developed some strategies for managing patients who have found their way to me after an unsuccessful cataract surgery. The patient profile is usually someone who is months out from their surgery and has failed to neuroadapt. Often, they have undergone ocular surface optimization for corneal dryness, as well as correction of any mild refractive errors with PRK, LASIK, or LRIs. They may have received an Nd:YAG capsulotomy.

During the consultation, I let the patient tell their story, and then I determine the nature of their complaints: is their issue a dysphotopsia necessitating an IOL exchange, or just residual refractive error?

THE PREOPERATIVE WORKUP

After a routine evaluation that begins with the manifest refraction before the IOP check, I use an algorithm to determine if I'm going to perform an IOL exchange (Figure). The main questions I ask: Is there a measurable refractive error present in the eye? And, will fixing it make the patient happy? If simulated refractive correction doesn't resolve their complaints, then I move toward an IOL exchange.

The two tools I use to help me plan the surgery are Dr. Hill's Vergence Formula to pick the new lens, and the Astigmatism Fix website by Drs. Berdahl and Hardten (especially in cases of a toric IOL). I download the IOL Exchange spreadsheet from Dr. Hill's site to calculate the new IOL power. I input the current refraction, my target refraction, and the current IOL's effective lens position. Because I often implant the new IOL in the sulcus, I have to use the bag-to-sulcus effective lens position adjustment.

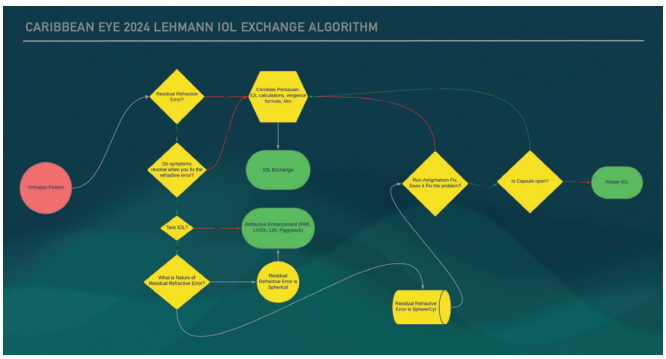

Figure. Dr. Lehmann's IOL exchange decision tree.

If the patient has a toric IOL and the capsule is open, I won't try rotating the lens. If the capsule is intact and the worksheet at astigmatismfix.com says that I could reduce the astigmatism to less than 0.50 D, then I will generally attempt an IOL rotation.

TECHNIQUE FOR STANDARD IOL EXCHANGE

To exchange a single-piece acrylic IOL implanted in the capsule with some fibrosis, I begin by instilling a dispersive viscoelastic underneath the haptic-optic junctions, because that's typically where the most fibrosis occurs. Then, I use a Sinskey hook to tilt one side of the lens up toward me, and I use scissors to cut the haptics before I rotate the optic into the anterior chamber. Whenever I've damaged capsules or zonules during these cases, it was because I tried to rotate the lens with the haptics firmly fibrosed into the bag. I may leave the haptics in the bag if they are too fibrosed or if the capsule is open.

I'll use viscoelastic to float the IOL up into the anterior chamber before dissecting it with a typical MST grabber and cutters. I'll remove the segments in thirds or halves.

IOL EXCHANGE WITH OPEN CAPSULE

If I need to exchange an IOL in an eye with an open capsule, I definitely plan to cut at least one of the optic-haptic junctions. After cutting off one haptic and lifting the optic into the anterior chamber, I may be able to spin the lens to get the second haptic out of the bag without causing striae or damage to the capsule.

The take-home point regarding IOL exchange with the capsule open (or still intact) is to consider amputating the haptics prior to elevating the optic out of the capsule. It is far more dangerous to attempt to rotate an IOL with fibrosed haptics than it is to amputate the haptics and even leave them in the far reaches of a fibrosed capsule. ■

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- Disclosures: None