

SURF AND TURF

A hybrid refractive IOL strategy that satisfies patients and simplifies their decision-making.



BY DAVID F. CHANG, MD

I am someone who struggles to decide between lobster and filet mignon at a nice restaurant. Having surf and turf as a menu option solves my dilemma. The same principle appeals to many of my advanced technology refractive IOL patients. Let me explain why.

PARALYSIS BY ANALYSIS

An intelligent patient in her 60s returned for a cataract surgery evaluation 3 years after she had been scheduled for surgery with a Clareon Vivity IOL (Alcon). Out of curiosity, I asked why she had canceled and delayed surgery for so long despite her poor vision. She explained that she simply could not decide which IOL she wanted. This anecdote highlights the angst and anxiety many patients experience when trying to determine which IOL is best for them.

Without an accommodating IOL, no available lens provides complete spectacle independence without optical side effects. With more designs than ever before, IOL selection has become increasingly complex for both patients

and ophthalmologists. The permanence of the decision often makes patients fearful of choosing the wrong lens—a concern that becomes magnified by conversations with friends or online accounts of patients who regretted their choices (see *The Paradox of Choice in Cataract Surgery*).

UNDERSTANDING PATIENTS' INDECISION

For patients who desire—or have historically enjoyed—good uncorrected distance vision, the choice often comes down to a refractive extended depth of focus (EDOF) IOL such as the Vivity or a diffractive trifocal IOL such as the Clareon PanOptix (Alcon). The limitations or shortcomings of each platform can complicate the choice between them.

Although most patients are satisfied with either lens, when patients who receive an EDOF IOL express dissatisfaction, the reason is often blurry near vision—especially if they were myopic or had some accommodative amplitude preoperatively. When patients tell us preoperatively that they would

not mind wearing reading glasses, they may be referring to reading a newspaper. Postoperatively, however, they may be surprised—and disappointed—to find they cannot read text messages or apply makeup without readers.

On the other hand, the improved near function provided by any multifocal IOL comes with the trade-off of glare and halos at night. Although most patients eventually adapt, there is always an unpredictable risk that they will not. Some patients who would probably love multifocal IOLs get scared off after hearing about someone who struggled with halos after cataract surgery.

Finally, a monovision or mini-monovision strategy may seem risky or counterintuitive to patients who have never experienced it with contact lenses. Indeed, some patients will be dissatisfied with this approach postoperatively and may be unhappy if the outcome in their distance eye is not close to plano.

THE BEST OF BOTH WORLDS

Patient satisfaction would be much higher—and IOL selection far simpler—if

we had a lens that, when implanted bilaterally, provided excellent binocular distance and intermediate vision, good vision for driving at night, and the convenience of viewing a cell phone or reading in bed without glasses. Although this ideal IOL does not yet exist, we can reliably meet these objectives by combining a refractive EDOF IOL, such as the Vivity, in the dominant eye with a diffractive trifocal IOL, such as the PanOptix, in the nondominant eye.

Since the expansion of the Vivity's power range last year, I have increasingly recommended this Vivity/PanOptix (VP) hybrid approach as the primary strategy for many patients. I have found that this combination consistently delivers excellent binocular distance and intermediate vision and allows patients to perform most near tasks under adequate lighting. I inform them that they will need to wear inexpensive, over-the-counter readers for extended reading and demanding near tasks such as sewing.

EXPLAINING THE OPTION TO PATIENTS

I explain to patients that the Vivity's strength is its excellent night vision performance, whereas the PanOptix offers better near vision—such as for seeing a cell phone. The VP hybrid approach therefore offers the best of both worlds. I reassure patients that, because we are targeting the same distance and intermediate vision in each eye, they will not feel imbalanced or need time to adapt, as is often the case with pseudophakic monovision. When I describe this approach as being like ordering surf and turf, patients invariably smile and appreciate that they are receiving the distinct benefits of both premium options—a positive rather than a compromise.

Beyond the optical benefits, I have been impressed by how much easier the VP hybrid recommendation makes the IOL selection decision for patients. The surf and turf proposal is often immediately met with an enthusiastic

THE PARADOX OF CHOICE IN CATARACT SURGERY

BY RICHARD TIPPERMAN, MD



As the number of decisions patients must make about cataract surgery continues to grow, the education and counseling process has become increasingly complex. Dr. Chang's surf and turf approach is an insightful strategy for addressing many of the issues that make it difficult for patients to navigate these choices with confidence.

One major challenge patients face is FOMO (the fear of missing out). When it comes to IOL selection, FOMO often combines with the human tendency to prefer decisions of omission rather than commission. This can result in anxiety and decision inertia, making it harder for patients to move forward with cataract surgery.

To overcome these feelings, patients often dive deeper into research—only to fall into the well-known cognitive trap of the paradox of choice. Rather than feel empowered by additional information, they often become overwhelmed, which further delays a decision. This is precisely why offering too many choices without a clear recommendation from the surgeon often leads to greater confusion and stress for patients.

This phenomenon was famously demonstrated by Iyengar and Lepper's jam experiment at a Draeger's Market in the San Francisco Bay Area.¹ Shoppers presented with a greater number of jams were more likely to browse and sample but significantly less likely to make a purchase than those who were offered a limited selection. Interestingly, one of the key conditions that reinforce the less-is-more heuristic is when the choice has a significant personal impact or is inherently complex—precisely the context of IOL selection. By contrast, if patients were offered 100 choices of surgical hair bonnet colors, they might have a preference, but they would not agonize over the decision, because it carries little significance. In the case of IOLs, however, both the volume of choice and the importance of the outcome compound the psychological burden.

Dr. Chang's surf and turf approach solves this problem by giving patients a choice—but a curated one. Presenting two distinct IOL options that together deliver a complementary visual outcome enables patients to recognize a solution that fits their needs without triggering FOMO or the paradox of choice. It simplifies the decision while preserving a feeling of agency.

Moreover, the surf and turf branding is brilliant. It not only describes the use of two distinct lenses but also evokes the ideas of luxury, quality, and the best of both worlds without sacrifice. Compare this to terms such as *mix and match*, which can be confusing and carry little to no emotional resonance.

Many surgeons stratify advanced technology IOL offerings with hierarchies such as good, better, best (eg, basic, lifestyle, premium or bronze, silver, gold/platinum). Surf and turf effectively communicates the idea of two different elements that naturally pair well—and elevates the concept with a premium connotation. Just imagine if Dr. Chang had called it *liver and onions*; the emotional effect would be entirely different. Surf and turf are widely understood as the premier option on any menu, and that is exactly the type of framing patients respond to when asked to make a high-stakes decision.

1. Schwartz B. More isn't always better. *Harv Bus Rev.* 2006;84(6):14-15. <https://hbr.org/2006/06/more-isnt-always-better>

RICHARD TIPPERMAN, MD

- Attending Surgeon, Wills Eye Hospital, Philadelphia
- Ophthalmologist, Ophthalmic Partners, Philadelphia
- Member, CRST Editorial Advisory Board
- rtipperman@mindspring.com
- Financial disclosure: None acknowledged

response such as, “I really like that idea” or “That sounds really great.” This stands in stark contrast to the hesitation and indecision that often accompany a patient’s choice between an EDOF and multifocal IOL alone, when they say things such as, “You’ve given me a lot to think about” or “I need to do more research before deciding.”

IMPLEMENTING THE VP HYBRID STRATEGY

I recommend implanting the PanOptix lens in the nondominant eye to make it easier for the brain to suppress the rings around lights at night. I determine which eye to operate on first based on the patient’s priorities. For example, someone whose chief complaint is night driving glare due to a cortical cataract would undergo surgery with the Vivity in their dominant eye first. In contrast, someone with nuclear sclerosis who is benefiting from the incidental convenience of lenticular myopia might first receive the PanOptix in their nondominant eye. Regardless, I explain to patients that they are essentially test-driving one lens first and that some patients choose the same IOL for their second eye because they like it so much.

Another approach is to implant a Vivity lens targeted for distance in the first eye and targeted for slight myopia in the second eye to enhance near visual function. For this strategy to be

successful, the outcome in the distance eye must be close to if not at plano. Thanks to binocular summation, the VP hybrid approach should provide superior distance vision and will be much more forgiving if the first eye ends up with some residual refractive error.

FROM BACKUP PLAN TO PREFERRED STRATEGY

For patients who are bothered by the PanOptix halos in their first eye, I have regularly offered a Vivity for their second eye. Similarly, for patients who are disappointed by their lack of near vision with the Vivity, I have often offered the PanOptix for their second eye. These clinical experiences gave me the confidence to begin routinely offering the VP hybrid as the primary strategy. Patients view receiving different IOLs positively when it is the intended approach. In contrast, when they expect to have the same IOL bilaterally, receiving a different IOL in their second eye is perceived as an unexpected deviation from the norm because something did not go as planned with the first eye.

With the VP hybrid plan, once patients experience the limitations of their first IOL postoperatively, they already expect the second, complementary platform to enhance their visual performance. I find that this reduces their postoperative concerns, complaints, indecision, and anxiety. Most patients continue with

the hybrid strategy for their second eye as originally planned. When they do not, it is because they are thrilled with the outcome in the first eye, so no one is disappointed.

REDUCING INDECISION AND IMPROVING SATISFACTION

For appropriate candidates, I now use the VP hybrid approach more frequently than bilateral PanOptix implantation. Many patients who previously would have selected bilateral Vivity IOL implantation owing to concerns about nighttime halos now choose the hybrid strategy as well.

Because both lenses are produced by the same manufacturer, they share the same material, chromophore, index of refraction, and A-constant. For a large percentage of my patient population, the VP hybrid approach has improved satisfaction, reduced anxiety and postoperative complaints, and—as with surf and turf—notably lessened their preoperative indecision over which IOL platform to choose. ■

DAVID F. CHANG, MD

- Clinical Professor, University of California, San Francisco
- Private practice, Los Altos, California
- Editor Emeritus, *CRST*
- Member, *CRST* Global Advisory Board
- dceye@earthlink.net
- Financial disclosure: Consultant (Alcon, Carl Zeiss Meditec, Johnson & Johnson Vision, RxSight)