

# MATCHING EYE, OPTIC, AND EXPECTATIONS

My decision-making framework for presbyopia-correcting IOLs.



BY JOHN P. BERDAHL, MD



**P**resbyopia-correcting IOL selection is ultimately a matching exercise: choosing the right optic for the right eye and aligning the choice with the right expectations. My triage framework starts with two questions:

- No. 1: Is the patient an appropriate candidate for a presbyopia-correcting IOL?
- No. 2: Are their expectations and personality traits compatible with that technology?

Over the past few years, my assessment of patient personality and expectations has remained fairly consistent, but I have become more flexible about ocular eligibility. In my experience, it can be difficult to predict which patients will be satisfied or dissatisfied when their eye is generally normal. As a result, I have become more willing to consider presbyopia-correcting options in eyes with certain irregularities.

## PATIENT FACTORS

I do not assume that a patient who is particular about visual quality is difficult or unreasonable. Many patients simply have high demands and high standards. The practical issue is that a presbyopia-correcting IOL may not consistently meet the standards of every patient, particularly when the margin for visual compromise is small.

## REFRAMING IOL EXCHANGE

One of my biggest changes over the past 3 to 4 years is that I no longer view an IOL exchange as a failure. Instead, I frame it as a planned contingency in appropriately selected cases, and it is discussed up front as part of shared decision-making.

## LENS SELECTION: WHAT I FAVOR AND WHY

### Eyes With Mild Comorbidity or Patients With High Expectations

The Light Adjustable Lens (RxSight) is often my go-to option when an eye is not pristine (eg, irregular astigmatism, epiretinal membrane, mild age-related macular degeneration) or when the patient is particularly demanding about visual quality.

I typically target distance vision in each eye and counsel the patient that they will require reading glasses for near tasks.

### Highly Irregular Eyes

When a large amount of irregular astigmatism or frank keratoconus is present, I have had good success with the IC-8 Aphera lens (Bausch + Lomb). In highly myopic eyes, I have achieved good outcomes by pairing the IC-8 Aphera with a piggyback EVO ICL (STAAR Surgical).

### When I Consider Trifocality Despite Irregularity

I have become increasingly willing to

consider trifocal IOLs in certain eyes with some corneal irregularity. In this situation, patient counseling is more explicit and risk-based. I emphasize that a trifocal IOL offers them the best chance of spectacle independence, the likelihood of full satisfaction may be lower than if their eye were pristine, and an IOL exchange is a reasonable contingency if their postoperative visual quality or satisfaction falls short (see the sidebar for an example of my counseling script).

### Plan B: Setting Expectations Before Surgery

I outline the off-ramp in advance. If a trifocal IOL does not meet the patient's needs, the alternative may be spectacles (readers or bifocals) and/or an IOL exchange focused on visual quality.

## RED FLAGS

I try to keep my exclusion criteria straightforward.

### Mismatched Expectations

If I sense that a patient expects more than what current technology can reliably deliver, I do not proceed with a presbyopia-correcting IOL.

### Limited Visual Potential

If the patient does not have a meaningful chance of achieving good postoperative

## COUNSELING SCRIPT: TRIFOCAL IOLS IN EYES WITH CORNEAL IRREGULARITY OR MILD RETINAL PATHOLOGY

"I understand that you want to be as free of glasses as possible after cataract surgery, and a trifocal IOL is our best option to achieve that goal. However, based on your ocular findings, your likelihood of being fully satisfied may be lower than what is reported in published studies. If you are comfortable accepting a meaningful chance that we may need to exchange the IOL for a different option, then I am willing to take that risk alongside you. If we need to exchange the lens, I do not want you to feel that we failed. I want you to understand that we pursued your goal and we have a reasonable backup plan if this specific approach does not deliver the visual quality you want long term. An IOL exchange does carry risk, but in my view, that risk is low enough in appropriate circumstances to justify the attempt when the potential benefit is significant."

visual acuity, I do not implant a presbyopia-correcting IOL.

When I am uncertain, I ask myself a simple question: If this were my eye, and I were my own surgeon, what would I choose? The answer is generally what I recommend to the patient. ■

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