Why I Finally Added Premium IOLs

The shift to refractive cataract surgery is inevitable for all surgeons.

BY KHIUN F. TJIA, MD

In an article in the November/December 2008 issue of *CRST Europe*, I explained why I focused on traditional cataract surgery. At that time, I was not yet convinced of the advantages of premium IOL technologies; I did, however, indicate a possible trend toward routinely offering them in my practice. Today, I am one of the most frequent users of premium IOLs in the Netherlands, with an average implantation rate of almost 20% toric and multifocal IOLs.

Why the change of heart? I started to feel increasing pressure from demanding patients and even worried about potential litigation issues if I did not inform patients about all treatment options preoperatively. I also recognized that surrounding practices would begin offering new IOLs at some point in time. In short, I added premium IOLs routinely in the second half of 2008 simply because of the benefits for the patients and the surgeon.

Visual outcomes and patient satisfaction with these lenses have been encouraging; however, I still consider myself a traditional cataract-surgery–focused surgeon without any interest in pure refractive surgery. I want to treat disease and restore vision rather than help people get rid of their spectacles or contacts. But when a patient requires cataract surgery, it does not bother me to explain all potential IOL options and give advice on which lens is the best for him.

The vast majority of my premium IOL activity is with toric IOLs. I firmly believe that astigmatism correction with toric IOLs offers great advantages for the patient; I do not see any medical downside to this technology. I offer, or at least mention, presbyopia-correcting IOLs to all cataract patients. However, I am rather reluctant to promote them too actively. Only to patients who indicate a true desire for spectacle independence do I give a thorough, 30-minute explanation of what to expect. I think that flawless patient expectation management is the key to a successful premium IOL practice.

I currently offer only multifocal IOLs for presbyopia correction, as I am not convinced that any accommodative capacity occurs with the single-optic accommodating IOLs currently available. However, the 0.75 D center add of the Crystalens HD (Bausch + Lomb, Rochester, New York) is an interesting concept, and other lower-add bifocal IOLs on the European market may have greater potential. I await longer-term clinical results before adding the dual-optic accommodating IOL to our armamentarium.

TAKE-HOME MESSAGE

- Consider adding premium IOLs for their benefits to the patient.
- One of the biggest hurdles is increased chair time.
- If you are just beginning, start with toric IOLs.

One of the biggest hurdles in the transition process to incorporating premium IOLs is the problem of significantly increased chair time for cataract consultations. The most obvious solution is to train dedicated staff members to handle most of the extra technical examinations and patient consultation. The caveat is that this strategy involves hiring more staff. If the surgeon performs all the extra work, total patient capacity will decrease. Unfortunately, I am bound by the strict bureaucratic system of a public hospital and therefore am not able to change our practice pattern easily, nor is it easy to hire additional ophthalmic technicians and optometrists.

I have a medium-high–volume cataract surgery practice and treat approximately 1,800 to 2,000 cases each year. My practice is part of a larger general practice that includes eight ophthalmologists, with a total annual surgical volume of 5,000 procedures. We foresee a tremendous challenge in the near future concerning the trend toward the refractive components of cataract surgery. The evolving technologies associated with refractive cataract surgery may provide superior patient outcomes, but we must learn how to incorporate such changes wisely. It is an inevitable process that, in my opinion, will benefit many patients and hopefully also surgeons. ■

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