

Cataract & Refractive Surgery

EUROPE

TODAY

June 2009

Getting to Know the **IQ ReSTOR IOL** **+3.0 D**

Study results and
clinical experience
from the Canadian
clinical investigators.



FEATURING

Moderators: Iqbal "Ike" K. Ahmed, MD, FRCSC • Theodore Rabinovitch, MD, FRCSC

Panel: John Blaylock, MD, FRCSC • Marino Discepolo, MD, FRCSC • Pierre Faber, MD, FRCSC

Glen Hoar, MD • Dominique Meyer, MD, FRCSC • Carl Peters, MD, FRCSC

Getting to Know the IQ ReSTOR IOL +3.0 D

PANEL



Iqbal "Ike" K. Ahmed, MD, FRCS (Moderator), is Assistant Professor at the University of Toronto and Clinical Assistant Professor at the University of Utah in Salt Lake City. He is a paid consultant to Alcon Laboratories, Inc. Dr. Ahmed may be reached at tel: +1 905 820 3937; e-mail: ike.ahmed@utoronto.ca.



Theodore Rabinovitch, MD, FRCS (Moderator), is Chief of the Department of Ophthalmology at Humber River Regional Hospital in Toronto. He performs laser refractive surgery at the Yonge Eglinton Laser Eye and Cosmetic Centre. He acknowledged no financial interest in any product or company mentioned herein. Dr. Rabinovitch may be reached at tel: +1 416 748 2020; e-mail: drrabinovitch@northtorontoeyecare.com.



John Blaylock, MD, FRCS, is Medical Director of Valley Laser Eye Centre in Abbotsford, British Columbia. He accepts research fees from Alcon Laboratories, Inc., and has been paid by honorarium. Dr. Blaylock may be reached at tel: +1 604 850 0808; e-mail: jfblaylock@vlec.ca.



Marino Discepola, MD, FRCS, is on staff at the McGill University Health Center and at St. Mary's Hospital in Montreal. He is also an assistant professor at McGill University, a supervisor of the Royal Victoria Hospital's Medical Student Elective Program, and a member of the McGill Cataract Teaching Committee. He accepts research fees from Alcon Laboratories, Inc., and has been paid by honorarium, and he consults for Allergan, Inc. Dr. Discepola may be reached at tel: +1 514 385 0530; e-mail: marino.discepola@mcgill.ca.



Pierre Faber, MD, FRCS, is Chairman of the Department of Ophthalmology at Providence Healthcare in Vancouver, British Columbia. He is Associate Professor of Ophthalmology at the University of British Columbia in Vancouver. He acknowledged no financial interest in or paid consultancies with any company mentioned herein. Dr. Faber may be reached at tel: +1 604 879 9311; e-mail: pierrefaber@shaw.ca.



Glen Hoar, MD, is a general ophthalmologist in Comox, British Columbia. He is an associate professor with the University of British Columbia. He acknowledged no financial interest in any product or company mentioned herein. Dr. Hoar may be reached at tel: +1 250 890 0089; e-mail: ghoar@shawbiz.ca.

Dominique Meyer, MD, FRCS, is President and Founder of Institut Privé de Chirurgie. She acknowledged no financial interest in any product or company mentioned herein. Dr. Meyer may be reached at tel: +1 418 687 7328; e-mail: drdominiquemeyer@hotmail.com.

Carl Peters, MD, FRCS, is Proprietor and Medical Director of South Okanagan Eye Surgeons and Surgical Director of Advanced Aesthetics Rejuvenation Clinic in Penticton, British Columbia. He accepts research fees from Alcon Laboratories, Inc., and has been paid by honorarium. Dr. Peters may be reached at tel: +1 250 770 3266; e-mail: carlpeters@telus.net.

Canadian Investigators' Clinical Study Results: The AcrySof IQ ReSTOR IOLs +4.0 D and +3.0 D

PARAMETERS AND RESULTS: THE SN6AD3

The Canadian clinical study of the AcrySof IQ ReSTOR IOL +4.0 D (the SN6AD3) started in late 2007 and is ongoing (data on file with Alcon Canada Inc., Mississauga, Ontario), although investigators have reported on some preliminary data.^{1,2} Seventy cataract patients have undergone bilateral implantation of the SN6AD3. Two-thirds of the patients are female, and their average age is 58 years. The preoperative mean spherical range was +4.25 to -8.00 D.

Binocular UCVA

Approximately 55% of the patients presented with binocular UCVA of worse than 20/50. Six months after bilateral implantation, about 60% of them achieved vision that was

20/20 or better. More than 90% of the patients had better than 20/30 vision, and all had 20/40 or better.

Binocular intermediate UCVA was measured at about 60 cm. More than 70% of the patients presented with intermediate vision of less than 20/50. After bilateral implantation, close to 20% achieved 20/30 or better, 70% achieved 20/40 or better, and close to 85% had 20/50 or better intermediate vision. Binocular near UCVA was measured at 40 cm. Approximately 75% of the patients had preoperative near vision worse than 20/50. At 6 months, about 75% of the patients saw 20/20 or better at near. Interestingly, near visual acuity improved over the course of the study; the percentage of patients with visual acuity of 20/20 or better increased from 1 month to 3 months to 6 months.

Approximately 85% of patients had near visual acuity of around 20/30 or better, and about 98% saw 20/40 or better.

Furthermore, data were collected on patients' UCVA and BCVA at their preferred reading distance at 1, 3, and 6 months. The results at each visit were essentially identical. The preferred reading distance on average was 32.5 cm, which was consistent with the results of the US Food and Drug Administration (FDA) studies³ (Figures 1 through 3).

Quality of Life Questionnaire

The clinical investigators asked the study participants to answer a series of questions and rate their agreement with a given statement on a scale of 1 to 5.²

Spectacle correction: When asked how often they wore glasses or contacts preoperatively, almost 75% of the patients said they always did. At 1, 3, and 6 months after the surgery, more than 80% of the patients did not require spectacles.

Difficulty with night vision: Preoperatively, about 55% of the patients described their nighttime visual symptoms as moderate or severe. After binocular implantation with the AcrySof IQ ReSTOR IOL +4.0 D, about 90% had no or minimal difficulty with night vision.

Halos: Before surgery, about 65% of the patients had no or minimal difficulty with halos. Afterward, 77% responded

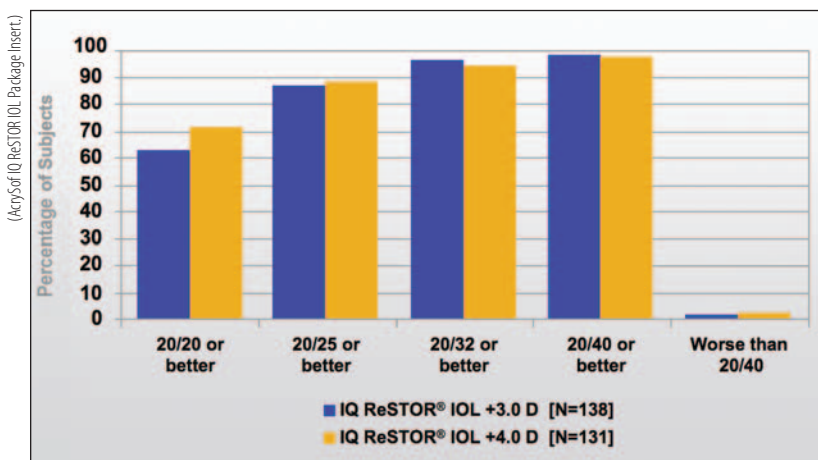


Figure 1. Cumulative, 3-month uncorrected binocular photopic distance visual acuity results from the US FDA clinical trials of the AcrySof ReSTOR IOLs.

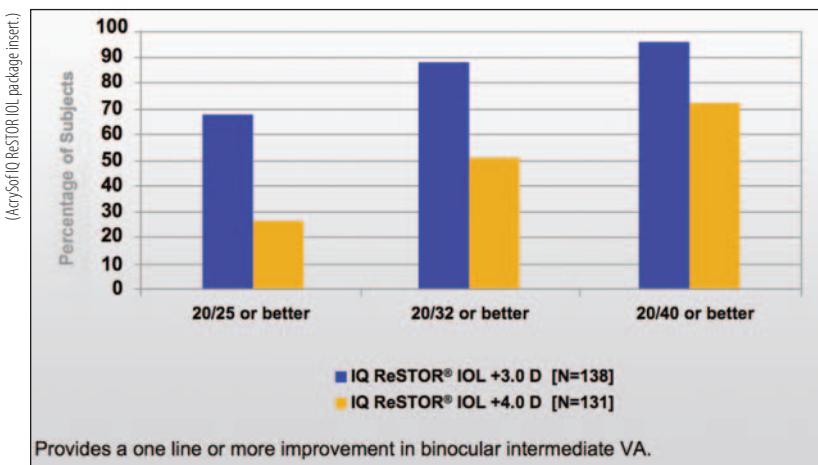


Figure 2. Cumulative, 3-month uncorrected intermediate photopic visual acuity results (at 50 cm) from the US FDA clinical trials of the AcrySof ReSTOR IOLs.

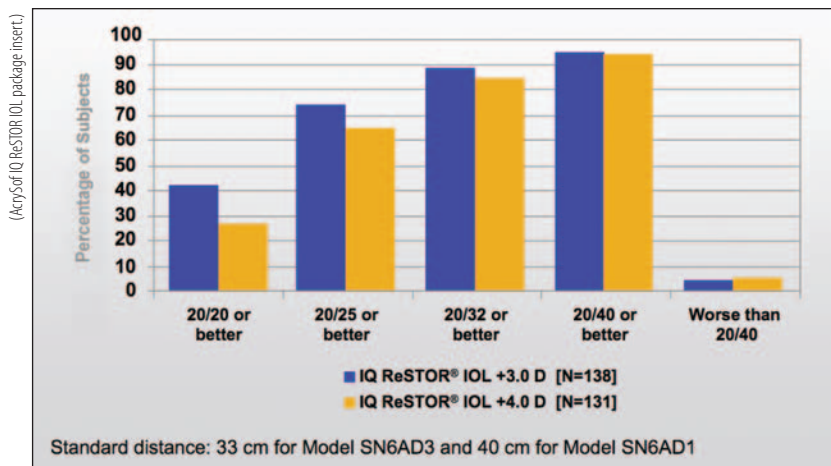


Figure 3. Cumulative binocular near photopic visual acuity results from the FDA clinical trials of the AcrySof ReSTOR IOLs.

that they experienced no or minimal halos—about a 10% improvement. Also, these symptoms improved over time.

Clinical Note: In terms of counseling patients preoperatively about their implant options, it is challenging to compare the pre- to postoperative incidence of halos with just presbyopia-correcting IOLs. Patients will be more interested in learning about the likelihood of experiencing halos with a multifocal relative to a monofocal implant. This is another opportunity to stress the risk/reward ratio of the diffractive multifocal IOL.

Difficulty watching TV or movies: Preoperatively, 62% of the patients said they had moderate-to-severe problems watching TV or movies. After surgery, 92% reported having no difficulty, and 8% of patients said they had minimal difficulty.

Caring for or playing with children: Preoperatively, approximately 56% of the patients reported having moderate or severe problems. Postoperatively, 95% said they had no difficulty, and 5% reported minimal difficulty.

Reading the time on an alarm clock: Preoperatively, 48% said they had issues. Postoperatively, 100% of the patients reported no or minimal difficulty.

Reading or near-range work: Preoperatively, 73% of the patients said they had moderate-to-severe problems. After bilateral implantation with the SN6AD3, 90% said they had no or minimal difficulty at near.

Using a computer (without putting on glasses): Preoperatively, 70% indicated moderate-to-severe trouble with this task. Approximately 85% of the patients said they had no or minimal difficulty after implantation.

Shaving or putting on make-up: Preoperatively, about

52% of the patients had moderate-to-severe difficulty. After surgery, about 98% reported minimal or no problems.

How satisfied are you with your vision? Patients in the bilateral AcrySof IQ ReSTOR +4.0 D study group were asked to rate their satisfaction with their postoperative vision on a scale of 1 to 10, from least satisfied to most satisfied. At 6 months, more than 80% of the patients reported being most satisfied with their postoperative vision.

Overall, the results from this 2007 Canadian Clinical Investigators study mirrored the outcomes of the FDA clinical trials and other studies. The AcrySof IQ ReSTOR +4.0 D IOL improved near and intermediate UCVA at 1, 3, and

6 months. It allowed 80% of patients to be spectacle free at 1, 3, and 6 months, and patient satisfaction was quite high after the procedure (Table 1).

Clinical Note: Patients' subjective reports on postoperative satisfaction can be influenced by how their physician sets their expectations and what value they feel they received for the price they paid. This year, postoperative patients may be second-guessing their expenditures because of the economic downturn. Therefore, mold patients' expectations chairside. Do not tell them they will never need glasses again after surgery. Set realistic expectations for their outcomes based on the available data.

EUROPEAN STUDY DATA: THE IQ +3.0 D

A European study of patients bilaterally implanted with the AcrySof IQ ReSTOR IOL +3.0 D (SN6AD1) comprised five sites and a total of 93 patients who were all younger than 70 years and had less than 1.00 D of preoperative

TABLE 1. PERCENTAGES OF +4.0 D PATIENTS REPORTING "NO OR MINIMAL DIFFICULTY" POSTOP

Night vision	90%
Halos	77%
Watching TV or movies	100%
Caring for or playing with children	100%
Reading an alarm clock	100%
Near-range work	90%
Using a computer	85%
Shaving or applying make-up	98%

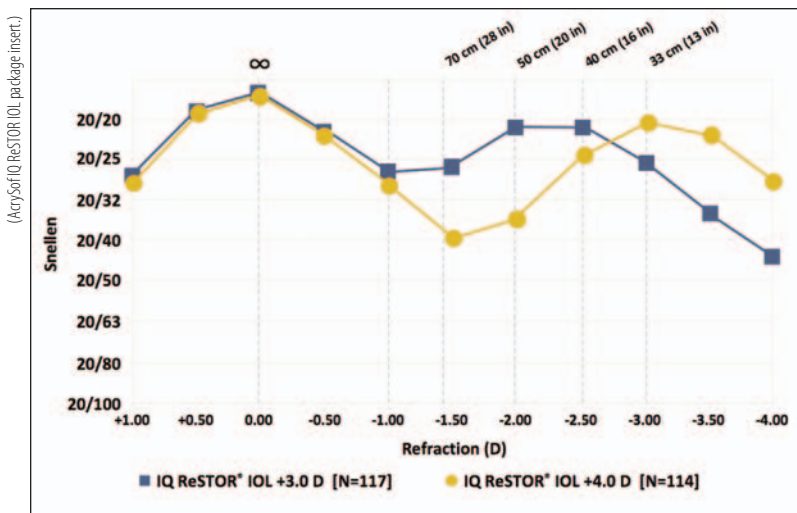


Figure 4. A comparison of mean defocus curves for AcrySof IQ ReSTOR IOLs 3 months after binocular implantation (from the FDA trials).

astigmatism. The patients underwent bilateral cataract surgery or clear lens extraction (an on-label use of the IQ ReSTOR +3.0 D lens in Europe). Data were collected through 6 months and included typical refractive data as well as patient-reported outcomes (data on file with Alcon Laboratories, Inc., Fort Worth, Texas).

Visual Acuity

The investigators tested distance visual acuity with the SN6AD1 at 50, 60, and 70 cm. This outcome (averaged) was slightly better than 20/20 at 40 cm, and the average acuity of the 93 patients at 50 cm was 20/30 (almost one line better than what was achieved with the AcrySof IQ ReSTOR +4.0 D lens in an FDA clinical trial). Also, these 6-month results are very similar to those from the IQ +3.0 D lens' FDA clinical trial.³

On the bilateral defocus curve, peak near visual acuity was between -2.00 and -2.50 D at the spectacle plane. Again, these binocular defocus curve data from the five-site European trial of the IQ ReSTOR +3.0 D lens closely match those from the FDA trial (Figure 4).³ Both results suggest three important things: (1) the point of near focus moved out; (2) there was a slight plateau between 2.00 and 2.50 D, which denotes a range of useable vision (effectively 40 to 50 cm); and (3) the intermediate vision achieved was about one line better at all distances than with the IQ ReSTOR IOL +4.0 D.

Spectacle Independence

In this five-center European trial, at 6 months, 88% of the patients bilaterally implanted with the IQ ReSTOR +3.0 D

reported being spectacle free, and 11% wore glasses sometimes. One subject wore correction for intermediate tasks, four patients wore correction for near tasks, and three wore correction for both distances. However, these individuals did not wear correction at these distances all the time.

Patient Satisfaction

The mean subjective satisfaction rating for these European patients was 8.4 based on a 10-point scale.

Visual Disturbances

Almost 80% of the European study patients reported no-to-mild glare or halos, and there were no reported issues with distorted near vision when looking at a cell phone. Also, fewer than 10% experienced severe halos, and fewer than 5% reported severe glare. Again, these results tie closely with those of the FDA trial as well as with the results from all 11 investigative sites around the world.

SOUTH AMERICAN BILATERAL RESTOR IOL +3.0 D STUDY DATA

The data from South American study sites for the bilateral implantation of the AcrySof IQ ReSTOR IOL +3.0 D include 55 patients, all younger than 70 years of age and with less than 1.00 D of astigmatism (data on file with Alcon Laboratories, Inc.). As in Europe, many South American countries permit on-label clear lens extractions with multifocal IOLs. The data at the time this monograph went to press are out to 6 months. Visual acuities were tested at 40 cm, 70 cm, and 4 m. The results were as follows:

- Visual acuity at all distances was better than 20/32.
- Ninety-six percent of the patients were free of spectacles at 6 months postoperatively.
- One subject wore glasses on rare occasions for distance viewing, and one subject wore them occasionally for near tasks.
- The mean patient-satisfaction score in this cohort was nine out of 10.
- Ninety-eight percent of these patients reported having no-to-mild visual disturbances regarding halos, glare, using a computer, driving at night, and overall night vision.
- Notably, the number of patients reporting no-to-mild visual disturbances was significantly higher than in the European cohort.

and adapt more easily to a lens that has both a larger *sweet spot* and better intermediate vision.

Dr. Blaylock: Per my own data, patients' near visual acuity is better with the bilateral implantation of the IQ ReSTOR +4.0 D IOL than the IQ ReSTOR +3.0 D. Intermediate visual acuity, however, is better with the bilateral implantation of the IQ ReSTOR +3.0 D lens.

Dr. Rabinovitch: Is the symptom of waxy vision (ie, vision that appears cloudy or smudged) still an issue with the aspheric ReSTOR IOLs? Do any of your patients complain of this symptom with other lenses?

Dr. Faber: I heard anecdotal suggestions that the aspheric AcrySof ReSTOR platform reduced this symptom, and I have had the same experience. I have not heard a patient describe waxy vision in over a year. Recently, I called in all of my bilaterally implanted aspheric IQ ReSTOR +4.0 D patients for checkups, and I asked them about halos, glare, intermediate vision, and waxy vision. I did not hear a single complaint about waxy vision.

“Having both of these lenses available lets me tailor patients' preferred vision.”

—Marino Discepolo, MD, FRCSC

Dr. Rabinovitch: I think patients' satisfaction with their IOLs sometimes depends on their understanding how the lenses work. Although my staff and I conducted a good amount of preoperative counseling with the ReSTOR +4.0 D IOL, we found that certain patients were unhappy with their reading vision. My staff and I had to educate them that they could move their reading material closer, and then they realized that they could indeed see better. One month later, these patients' satisfaction had increased significantly as a result of changing their habitual reading distance and because their range of vision had improved with time. Has anyone else felt that thorough patient education has improved satisfaction rates at 3 or 6 months?

Dr. Blaylock: Hyperopes in particular may need to be taught to bring reading material in closer after surgery, but overall, complaints about reading distance with the ReSTOR +4.0 D lens always improve with time. With the traditional

“The biggest improvements [with the IQ ReSTOR +3.0 D IOL] are a greater range of vision and reading at a more comfortable distance.”

—Carl Peters, MD, FRCSC

spherical AcrySof ReSTOR IOL, glare, halos, and complaints about intermediate vision often persist a year later.

Dr. Faber: The biggest complaint I hear is about decreased near vision in poor lighting conditions.

Dr. Rabinovitch: I have found that postoperative education is as important as preoperative education with these diffractive multifocal lenses. I have had success with bringing patients back at 3 months and teaching them how to retrain their habits. This seems to have improved my 6-month and 1-year satisfaction rates.

THE ACRYSOF IQ RESTOR IOL +3.0 D

Dr. Rabinovitch: Let's talk about the IQ ReSTOR +3.0 D lens. In my opinion, it gives patients more comfortable vision for daily activities. In particular, most of these patients seem much happier holding reading material at 40 cm as opposed to 33 cm with the ReSTOR +4.0 D lens. Have you investigators had the same experience?

Dr. Peters: I agree entirely. Patients are enjoying a better quality of life at all ranges of vision with the IQ ReSTOR +3.0 D IOL. The biggest improvements are a greater range of vision and reading at a more comfortable distance. These are the main reasons I have switched from the ReSTOR +4.0 D to implanting the IQ ReSTOR +3.0 D lens.

Dr. Rabinovitch: How has chair time changed with the AcrySof IQ ReSTOR IOL +3.0 D? Do you counsel these patients any differently than you do ReSTOR +4.0 D lens candidates? Also, what has been your level of comfort and satisfaction with the lens?

Dr. Peters: Like I did with the ReSTOR +4.0 D, I still emphasize to patients that the IQ ReSTOR +3.0 D IOL will reduce their need for glasses in 80% to 90% of their daily activities. Whereas a number of my ReSTOR +4.0 D lens recipients were disappointed because they required the use of +1.50 D readers for intermediate tasks, rarely have any of

my IQ ReSTOR +3.0 D lens patients needed any add. This lens allows me to deliver better results to my patients due to its greater range of vision and depth of focus.

Dr. Rabinovitch: Are you spending less or the same amount of time counseling preoperative patients about issues regarding intermediate vision with the AcrySof IQ ReSTOR +3.0 D than the +4.0 D IOL?

Dr. Peters: I spend about the same amount of time, just to be thorough.

Dr. Discepolo: I also spend about the same amount of time on preoperative counseling; I just explain this lens a little differently than I do the ReSTOR +4.0 D IOL. I tell patients that the +3.0 D lens will give them better intermediate vision for tasks like reading at the computer, but their near acuity will not be quite as sharp for very small print, such as stock quotes.

“The improvement patients get with the IQ ReSTOR +3.0 D over the +4.0 D IOL is a smoother, more natural progression from near to intermediate.”

—Glen Hoar, MD

I also counsel patients the same about halos and glare. The halos that my AcrySof ReSTOR patients experience are different from those that patients with cataracts see. Cataract halos resemble a diffuser on lights, but my younger ReSTOR patients who have this symptom describe actual rings around lights. Also, these patients see rings around headlights when cars are far away, but as the car gets closer, the rings disappear. I am able to reassure my patients that as a light source gets closer, the rings will dissipate.

Dr. Rabinovitch: Dr. Faber, please talk more about potential vision issues in dim light.

Dr. Faber: Since the IQ ReSTOR +3.0 D IOL came out, I no longer implant the +4.0 D lens. Although the IQ ReSTOR +3.0 D IOL provides somewhat better intermediate vision than its predecessor, its near acuity is still very good. In terms of counseling, I tell my patients that they will have a reasonable range of vision and good reading vision, but that they may have some trouble reading in poor light. There are two key points to my discussion: (1) to tell patients that this

“I feel that [the IQ +3.0 D lens] should not be labeled as an intermediate lens, but a comfort lens. It will enable patients to perform daily activities without glasses 90% to 95% of the time.”

—Theodore Rabinovitch, MD, FRCSC

lens is very good, but not perfect, and to not expect the vision they had at age 25; and (2) to emphasize that the ReSTOR +3.0 D IOL will eliminate their need for glasses 80% to 90% of the time.

Dr. Discepolo: In my experience, patients understand the concept of different adds, because they often buy reading glasses. Also, it does not take long to ask patients at what distance they like to hold things, and I find that they feel more involved in the decision if they choose the distance at which they want to work.

Dr. Rabinovitch: I have to agree. I also feel that the IQ ReSTOR +3.0 D IOL's near/reading vision is excellent and of no lesser quality than that of the ReSTOR +4.0 D lens. IQ ReSTOR +3.0 D patients read at a sharp J1 and often J1+; they can read the tiniest print.

Dr. Hoar: I think we have to put in the chair time no matter which lens we are going to use. Any counseling done after the surgery is backtracking in the patient's mind. As for reading vision, the improvement patients get with the IQ ReSTOR +3.0 D over the +4.0 IOL is a smoother, more natural progression from near to intermediate.

Dr. Rabinovitch: Dr. Blaylock, what are your impressions of the IQ ReSTOR 3.0 D lens' reading vision?

Dr. Blaylock: I am in the process of teasing out the data on my bilaterally implanted ReSTOR +3.0 D IOL patients, but I am finding that bilaterally implanted +3.0 D IOLs give a longer depth of focus than bilaterally implanted ReSTOR +4.0 D lenses.

Dr. Discepolo: I also notice a difference in patients' near vision between bilaterally implanted IQ ReSTOR +3.0 D and ReSTOR +4.0 D IOLs (I am conducting studies of both groups). Without question, the +4.0 D patients hold reading

“My happiest days are my postoperative days; I look forward to seeing my IQ ReSTOR +3.0 D lens patients the day after surgery and even more so the week after surgery.”

—Marino Discepolo, MD, FRCSC

materials closer, because the lens has stronger magnification. I do not see the IQ ReSTOR +3.0 D lens patients read J1+++ like I do the +4.0 D patients, although the reading vision of the former group is very good.

Dr. Rabinovitch: Perhaps, but IQ ReSTOR +3.0 D lens patients can still read the stock page and the small print on an eye drop bottle. I feel that this IOL should not be labeled as an intermediate lens, but a comfort lens. It will enable patients to perform daily activities without glasses 90% to 95% of the time. I think that for reading labels and checking prices at a grocery store, most individuals will be much happier with the IQ ReSTOR +3.0 D than the +4.0 D lens, especially the younger patients who were dissatisfied with the close-range vision the ReSTOR +4.0 D lens provided. I operate on a lot of uveitis patients who have early cataracts, and I used to implant them with the ReSTOR +4.0 D IOL, because at the time, it was the best choice for them. However, this group of patients was particularly vocal about the lack of intermediate vision. Now, I am a lot more comfortable recommending the IQ ReSTOR +3.0 D lens to these young patients.

WHERE THE ACRYSOF IQ RESTOR IOL +3.0 D FITS IN THE PRACTICE

Dr. Rabinovitch: I would like to discuss where we are positioning the AcrySof IQ ReSTOR IOL +3.0 D in our daily practices and how its availability has had an impact on our use of other IOLs.

When this IOL came out, I experienced something I hadn't before with multifocal implants: patients were satisfied within a week of implantation, and I did not have to hold their hands for a month or two. During the preoperative counseling, I review all the issues they might have with this lens. If the patient does not choose the lens that day, when he calls the office with his decision, I make sure he is scheduled for one more counseling session so I can review once more the issues of glare and halos, intermediate vision, and the need for patience during the neuroadaptation period.

My IQ ReSTOR +3.0 D patients seem to have more of an initial *wow factor* and a little less trouble adjusting their reading distance than my ReSTOR +4.0 D patients. Within a couple weeks after the second eye's implantation, my +3.0 D patients seem to be happy. Some are blatantly ecstatic and describe the IQ ReSTOR +3.0 D as a miracle lens! This has been a unique experience for me that has changed the way I deal with patients pre- and postoperatively. When these patients come in after surgery, I am relaxed, because I expect them to be happy. Therefore, I have more confidence in the IQ ReSTOR +3.0 D implant.

One of the concerns with the previous version was that we knew patients were going to have halos and glare, but they also had an issue with the close range of their reading vision. The IQ ReSTOR +3.0 D lens has eliminated the latter issue; it increases the range of vision. A few of these patients still experience some halos and glare, but most of them adapt to these symptoms. Overall, I find that the IQ ReSTOR +3.0 D patients adjust to their new vision faster and are more satisfied with it.

Dr. Discepolo: I agree with you 100%. My happiest days are my postoperative days; I look forward to seeing my IQ ReSTOR +3.0 D lens patients the day after surgery and even more so the week after surgery.

Dr. Peters: I do not have to try to inconspicuously watch my postoperative IQ ReSTOR +3.0 D patients in the examination room to see if they are reading a magazine without glasses. I am confident they are happy with their vision.

Dr. Rabinovitch: How often have any of you walked into an examination room to see a postoperative IQ ReSTOR +3.0 D lens patient reading a newspaper or magazine comfortably?

Dr. Hoar: I have seen this, and it's a telltale sign of the lens' efficacy. Sometimes, these patients are reading a magazine without their glasses, and they do not even realize it until I point it out to them. That comfortable reading range is a nice benefit of the IQ ReSTOR +3.0 D IOL. Compared with the +4.0 D lens, these patients do not have to work to find the *sweet spot* or train their brain to use the lens in different positions.

Dr. Rabinovitch: How far apart do you schedule the second implantation? I wait about 1 week.

Dr. Discepolo: I book them about 1 or 2 months apart, depending on the waiting list.

Panel Discussion

DIFFERENCES BETWEEN THE ACRYSOF IQ RESTOR IOLs +4.0 D AND +3.0 D

Dr. Rabinovitch: Let's begin by discussing our numbers of patients who are happy with the AcrySof ReSTOR +3.0 D lens versus the +4.0 D lens, the aspheric and nonaspheric versions, as well as other IOLs. I feel that patient satisfaction is a true measure of an IOL's efficacy. Do you think recipients of the AcrySof ReSTOR +3.0 D lens are happier overall than those who received the +4.0 D lens or the Array IOL or the ReZoom multifocal IOL (the last two manufactured by Abbott Medical Optics Inc., Santa Ana, California)?

Dr. Faber: I have implanted many different types of multifocal IOLs. Most of my patients who received the nonaspheric AcrySof ReSTOR +4.0 D IOL have been happy, but it is the unhappy patients whom I remember. When it first debuted, most problems with the ReSTOR +4.0 D IOL likely resulted from surgeons' inexperience with the lens. For example, we early adopters had to learn how improve our patient selection, optimize the tear film, minimize astigmatism, and use NSAIDs pre- and postoperatively. Thankfully, I always used NSAIDs. Fortunately, when using the AcrySof ReSTOR IOL as opposed to any other multifocal or accommodating lens, most patients see 20/20 at near on day 1, and we can safely promise them that outcome. My 1-day postoperative ReSTOR patients sit in the waiting room reading a magazine without glasses, and the other patients will ask me for the lens that those patients received.

Dr. Rabinovitch: I agree that although we have newer and better IOLs, better patient selection has also factored into improved results. Dr. Blaylock, are you now more selective with presbyopia-correcting lenses compared with when you began using the AcrySof ReSTOR +4.0 D IOL? Do you think the improvement in outcomes surgeons are experiencing is a result of better patient selection, of switching to the aspheric AcrySof IQ ReSTOR +4.0 D IOL, or both?

Dr. Blaylock: I agree with Dr. Faber that the improved results with the IQ ReSTOR +4.0 D IOL are largely due to a combination of improved patient selection and greater surgeon experience. On the whole, I think surgeons who implant the AcrySof ReSTOR series have gotten better at counseling patients and giving them more realistic expectations. I have tracked my outcomes with these lenses, so I am better able to predict patients' results, and my staff and I always warn them if we think they may need glasses at any visual range.

“Fortunately, when using the AcrySof ReSTOR IOL, most patients see 20/20 at near on day 1, and we can safely promise them that outcome.”

—Pierre Faber, MD, FRCSC

Dr. Rabinovitch: To the panel: Regarding the aspheric ReSTOR +4.0 D lens, what have you been telling your patients preoperatively to expect from their postoperative intermediate vision? Do you counsel them any differently with the IQ ReSTOR +3.0 D lens?

Dr. Discepolo: I am still using the AcrySof IQ ReSTOR +4.0 D lens on select patients. For example, an individual presented with nuclear sclerotic cataracts in both eyes; he was -5.00 D in one eye and -1.00 D in the other. During my preoperative examination, I always give patients something to read and ask them at what distance they would like to be able to hold the material. This patient was adamant that he wanted to be able to hold reading material at about 12 inches, because that is what he was accustomed to with his -5.00 D eye preoperatively. This is the criterion by which I choose between the IQ ReSTOR +3.0 D and the IQ ReSTOR +4.0 D lenses. I typically implant the ReSTOR +4.0 D lens in patients who prioritize their near vision, such as jewelers, watch repairmen, and elderly women who do needlepoint. Having both of these lenses available lets me tailor patients' preferred vision. I strongly recommend that surgeons continue to use the IQ ReSTOR +4.0 D lens, because it is very useful for certain patients.

Dr. Rabinovitch: Dr. Peters, why did you stop using the IQ ReSTOR +4.0 D IOL bilaterally? Do you think surgeons will abandon it for the IQ ReSTOR +3.0 D lens or continue using the +4.0 D lens for moderately high myopes who are used to close-range vision?

Dr. Peters: I switched to the IQ ReSTOR +3.0 D IOL because the majority of presbyopic patients prefer a farther reading point. However, the IQ ReSTOR +4.0 D lens is still available for those who prefer close-range near vision.

Dr. Rabinovitch: My experience has been the same. Although many patients will say they want to be able to read up close, unless their occupation dictates a need for very fine close focus (eg, tailors), I believe they will be happier

Dr. Faber: I still book them 1 week apart. I think that even the IQ ReSTOR +3.0 D patients are happiest after their second eye has been implanted. I think it improves patients' comfort.

Technology Note: Robert Cionni, MD, of Cincinnati, Ohio, published an article in the June 2009 issue of the *Journal of Cataract and Refractive Surgery* of 32 patients implanted with the AcrySof ReSTOR IOL in one eye and a phakic lens in the contralateral eye, 20 patients with a contralateral monofocal IOL, and 12 with a contralateral ReSTOR IOL to compare bilaterally implanted ReSTOR lenses with the other two groups.⁴ The results showed that 20/40 to 20/32 vision was possible with the singular implantation of the ReSTOR lens. The distinction between these patients and bilaterally implanted ReSTOR patients came at the 20/25 to the 20/20 range. Dr. Cionni concluded that unilateral implantation with the AcrySof ReSTOR IOL provides good functional vision, although bilateral implantation is more efficacious.

NEGATING MIXING AND MATCHING

Dr. Rabinovitch: I think the biggest impact of the IQ ReSTOR +3.0 D IOL will be how it will nearly eliminate the discussion about mixing and matching with other brands of lenses. It will be nice to have one less option to discuss.

Dr. Faber: I think that many patients like the idea of having the same implant in both eyes, which is why I am apprehensive about mixing the IQ +3.0 D and the IQ +4.0 D ReSTOR lenses. I implant the lenses about 1 week apart, and I see the patients on day 1 and then 3 or 4 days later so I can check their refraction and they can tell me if the range is too close or otherwise. I rarely mix the IQ ReSTOR +3.0 D lens with anything else.

Dr. Rabinovitch: Overall, however, for the average presbyopic patient, the IQ ReSTOR +3.0 D lens has matched their expectations for day-to-day performance. Dr. Peters, would you agree?

Dr. Peters: Absolutely. I practice in a rural setting, and the ability to give my patients good distance through near vision is a big step up.

Technology Note: Although the AcrySof IQ ReSTOR +3.0 D IOL has nine diffractive steps versus 12 on the +4.0 D lens, the light distribution pattern is the same for both lenses. Yet, early anecdotal as well as clinical data on the IQ ReSTOR +3.0 D lens are showing a slight improvement at distance over the +4.0 D IOL.

"Because the IQ ReSTOR +3.0 D lens gives a greater range of intermediate vision and more of an accommodative range at near, I now implant fewer accommodative lenses."

—Carl Peters, MD, FRCSC

Dr. Rabinovitch: One of the biggest changes I have noticed with the IQ ReSTOR +3.0 D IOL is that my technicians are seeing great results in postoperative patients right away. They no longer have to wait 6 months to retrain the patients' reading habits. We all know that when our staff members are confident, they convey that feeling during their patient consultations.

Dr. Discepolo: If you want to be successful with this new technology, first and foremost, your staff has to believe that it works. We surgeons have to show our technicians and counselors that it works, because otherwise they will not be able to counsel the patients effectively and convincingly. After surgeons have implanted the first few of these lenses, their staff members will see the results, and it will be easier for them to explain the benefits of the lens to the patients.

THE ACRYSOF IQ RESTOR IOL +3.0 D VERSUS AN ACCOMMODATING IOL

Dr. Rabinovitch: How does the AcrySof IQ ReSTOR IOL compare with an accommodating IOL?

Dr. Blaylock: I will consider an accommodating IOL for certain patients who need excellent distance vision with absolutely no glare and halos, such as pilots and truck drivers who work at night.

Dr. Faber: I think the big problem with accommodating lenses is reading vision. My patients who have the Tetraflex IOL (Lenstec, Inc., St. Petersburg, Florida) say that they see well at distance, but they have difficulty reading. I never hear that complaint from AcrySof IQ ReSTOR patients. I feel that, properly educated, ReSTOR patients are much easier to deal with than accommodating lens recipients.

Dr. Peters: The Tetraflex has predictable vision, but its near point is an issue for many patients. With the AcrySof IQ ReSTOR +4.0 D IOL, I would ask the patient if he preferred very good distance vision and very predictable near vision, or if he wanted a greater range of vision in exchange

for less predictable near vision (if he chose the latter, I would offer a Tetraflex). Because the IQ ReSTOR +3.0 D lens gives a greater range of intermediate vision and more of an accommodative range at near, however, I now implant fewer accommodative lenses. My patients feel more comfortable choosing the IQ ReSTOR +3.0 D lens, and I feel more comfortable offering it to them.

Dr. Blaylock: I have not had the same problems, but I do anticipate using the AcrySof IQ ReSTOR +3.0 D IOL in some patients whom I previously would have implanted with the Tetraflex.

Dr. Discepolo: I am pleased enough with the AcrySof IQ ReSTOR +3.0 D and +4.0 D lenses that I do not foresee using an accommodating IOL in the next year.

Dr. Peters: I am also moving away from the accommodating IOLs in favor of the ReSTOR lenses.

Dr. Rabinovitch: Certainly, there are some issues of predictability and refractive surprises with accommodative lenses that we will never experience with a ReSTOR lens.

“I feel like we have finally found a solution that will reduce the number of unhappy patients and greatly increase the number of happy patients in our practices.”

—John Blaylock, MD, FRCSC

Dr. Blaylock: I do not think patient satisfaction is linked to near vision as tightly as we thought. Counterintuitively, in an older study my team and I conducted with the AcrySof IQ ReSTOR +4.0 D IOL, patients' near vision did not correlate with their satisfaction; patient satisfaction correlated most strongly with uncorrected distance vision. I think that intermediate acuity is a better indicator of patient satisfaction than near vision.

Dr. Rabinovitch: I completely agree. I think the fact that the IQ ReSTOR +3.0 D IOL improves this social distance has influenced surgeons to recommend this lens to their patients. Dr. Peters, would you agree?

Dr. Peters: Yes, I can recommend the AcrySof IQ ReSTOR +3.0 D lens to patients who fit the criteria we discussed

earlier without fearing that they will complain postoperatively about their reading distance, computer distance, playing cards, etc. This lens suits the needs of patients who will benefit from stronger intermediate vision and do not mind using readers for close-range vision.

Clinical Note: Myopes, not accustomed to wearing glasses to read, will always have to wear glasses with a traditional implant. The AcrySof IQ ReSTOR IOL +3.0 D, with both distance and near foci, addresses this issue.

Dr. Blaylock: I use the -3.00 D glasses (I call them the *Elton John glasses*) on many patients, happy or unhappy, because I want to show them the vision they would have had if they had chosen the standard lens. Then, they tell all their friends how successful their surgery was. This strategy has been a good practice builder for me.

Dr. Hoar: If the patient is reluctant to lose his reading vision, I will use Alcon's red -3.00 D glasses to show him what his vision would be otherwise.

Dr. Rabinovitch: The -3.00 D glasses test is quite valuable. I also think it is important in the preoperative counseling to remind these patients that today's technology cannot mimic their natural visual system, but it can get close. They should expect to adapt to a new visual system, and we must stress what they are gaining versus what they are losing.

Dr. Faber: Presbyopia-correcting IOLs are allowing us to approach patients' vision differently. We now have options to give individuals the vision they prefer.

Dr. Blaylock: After a decade of implanting presbyopic refractive lenses, I feel like we have finally found a solution that will reduce the number of unhappy patients and greatly increase the number of happy patients in our practices. We used to talk explantation rates with multifocal IOLs, but this is no longer an issue; we do not expect to ever have to explant an AcrySof IQ ReSTOR +3.0 D lens. This lens has changed my practice and increased my confidence immensely. The surgical day is much more satisfying when you are not anticipating anxiety from your staff or your patients. Overall, I think the IQ ReSTOR +3.0 D is a fantastic new IOL.

Dr. Discepolo: The AcrySof IQ ReSTOR +3.0 D IOL has made ophthalmology even more fun.

Dr. Hoar: The IQ ReSTOR +3.0 D IOL has smoothed out the transition from near to intermediate vision. Difficulty

with reading labels at the grocery store was a common complaint from patients implanted with the +4.0 D, but not with this lens. Much of our life is spent at an intermediate distance, and I think this lens takes care of that.

Dr. Peters: For any surgeon who is starting out with multifocal IOLs, this is probably the safest and easiest platform to begin with. It is a proven platform that delivers successful outcomes and happy patients.

EARLY RESULTS: BLENDING THE ACRYSOF IQ RESTOR IOLs +3.0 D AND +4.0 D

Implanting the AcrySof IQ ReSTOR +3.0 D IOL bilaterally provides the best visual acuity. In fact, when five European investigators were asked if they would study a cohort of patients with contralateral IQ +3.0/+4.0 D lenses to see how this combination performed, all declined to participate on the basis that they believed the symmetry provided by the bilateral implantation of the IQ +3.0 D lens at near was preferable, because it was what they called *physiologically correct*. Nevertheless, patients who already have one IQ ReSTOR IOL +4.0 D may benefit from receiving an IQ ReSTOR +3.0 D lens in their second eye as opposed to a second IQ +4.0 D implant. Based on 3-month data from 11 study sites around the world, average near UCVA for each combination are 20/16 with bilaterally implanted IQ ReSTOR +4.0 D lenses, 20/17 with a +3.0/+4.0 D combination, and approximately 20/20 with bilaterally implanted IQ +3.0 D IOLs. Intermediate UCVA (at 60 cm) is similar between the +3.0/+3.0 D and the +3.0/+4.0 D combination. Three-month data on a cohort of 20 patients implanted contralaterally by Charith Fonseka, MD, of Sri Lanka^{5,6} showed a range of 20/20 to 20/25 near UCVA from 40 to 70 cm. More than half of the patients maintained 20/32 intermediate UCVA at 50 to 60 cm. These data are similar to visual acuity outcomes obtained from the ReSTOR's South American Clinical Study (Figure 5).

A study conducted in Venezuela by Enrique Suarez, MD, comparing bilaterally implanted IQ ReSTOR +3.0 D lens patients (78 eyes) with a small group of contralaterally implanted +3.0/+4.0 D eyes (18 eyes) showed that nearly 30% of the contralaterally implanted patients achieved 20/20 vision or better at near UCVA.⁷ A higher percentage of contralateral patients achieved near UCVA of 20/25. The preferred reading distance for the +3.0/+4.0 D patients was about 3 cm closer than that for the bilaterally

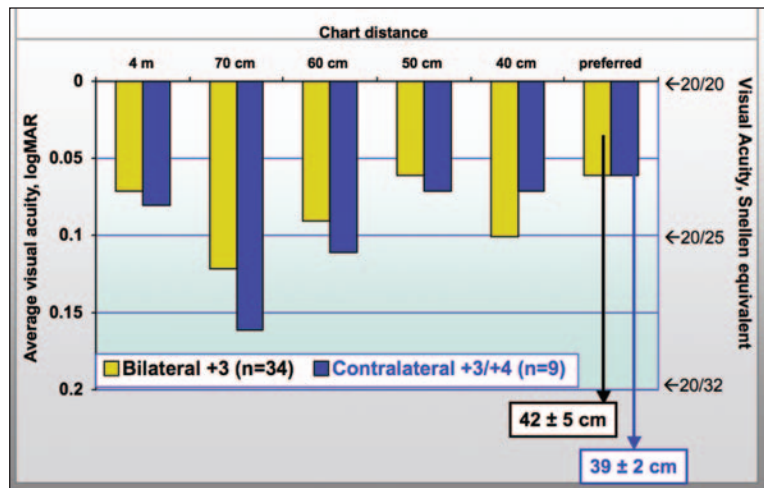


Figure 5. The mean binocular UCVA results from the South American study of the AcrySof ReSTOR IOLs, bilateral and contralateral implantations.

implanted IQ ReSTOR +3.0 D patients. The tradeoff in their intermediate range was very small.

Dr. Ahmed: Who has tried implanting an IQ +3.0 D IOL in a patient who already has an IQ +4.0 D lens in the other eye?

Dr. Faber: I have not tried this. I began implanting the IQ ReSTOR +4.0 D lens bilaterally and am now using the +3.0 D version bilaterally. I have not felt the need to mix the two.

Dr. Discepolo: I am presently conducting a study of bilaterally implanted IQ ReSTOR +3.0 D patients, and I may try mixing the two after that. I still see a place for using the IQ +4.0 D lens, because it provides impressive near vision. If possible, I would like to be able to give my patients that excellent near vision with the good intermediate vision of the ReSTOR +3.0 D lens, but that possibility remains to be seen.

Dr. Blaylock: I was reluctant to try this combination at first, but I implanted a few patients contralaterally after I was convinced of its logic. Although my data are preliminary,⁶ my outcomes were very good, and these patients have a very functional range of vision. However, there may be more of an adaptive curve with mixing the IQ ReSTOR +3.0 and +4.0 D lenses that seems to last about 2 weeks (again, based on my early experience). My data do show that a contralateral +3.0/+4.0 D implantation gives a longer depth of focus than bilateral +3.0 D lenses. We're still trying to match these lenses to the right patients, but we are finding new and very exciting data with the +3.0/+4.0 D

combination. I believe this mix represents a great opportunity for people who want strong intermediate vision.

Dr. Meyer: My patients with the AcrySof IQ ReSTOR +3.0/+4.0 D blended add have adapted rapidly to their postoperative vision.

Dr. Ahmed: Do patients implanted bilaterally with the IQ ReSTOR +3.0 D lens complain about their near vision?

Dr. Meyer: No.

Dr. Ahmed: Then, is there a benefit to mixing these lenses?

Dr. Meyer: Only for patients who need to read very fine print. However, these patients must be willing to trade a bit of intermediate vision in exchange for enhanced near vision.

Dr. Blaylock: I am implanting the IQ ReSTOR +3.0 D lens in the dominant eye and the IQ +4.0 D lens in the nondominant eye. I do not know if this is the best strategy or not, but it is what I am doing at this time.

“In my opinion, the AcrySof IQ ReSTOR IOL +3.0 D is the first lens on the market that gives the surgeon the confidence of being able to provide good near, intermediate, and distance vision with minimal patient complaints.”

—Theodore Rabinovitch, MD, FRCSC

Dr. Peters: I had a few patients with the IQ ReSTOR +4.0 D lens in one eye who were somewhat dissatisfied with the shortness of their near range. I offered these patients the option of receiving the IQ +3.0 D lens in the other eye, and it nicely resolved their concerns. Overall, however, I would recommend that surgeons who are newly adopting presbyopia-correcting IOLs begin with implanting the IQ ReSTOR +3.0 D IOL bilaterally. Bilateral implantation is an effective and less complicated strategy with which to begin.

Dr. Ahmed: Which eye do you each implant first with the contralateral approach?

Dr. Meyer: I always implant the nondominant eye first, so that I can check the biometry before working on the

“Overall, I would recommend that surgeons who are newly adopting presbyopia-correcting IOLs begin with implanting the IQ ReSTOR +3.0 D IOL bilaterally.”

—Carl Peters MD, FRCSC

dominant eye. There is no difference between the IQ ReSTOR +3.0 D and +4.0 D lenses in terms of hitting the biometry, but it is more important to be exact in the dominant eye.

Dr. Ahmed: I am not so sure that there is no difference in hitting the mark between the IQ ReSTOR +3.0 D and +4.0 D lenses. I think the IQ ReSTOR +3.0 D lens is a little more forgiving in terms of hitting the refractive target. It gives a little more depth of focus and range than the +4.0 D IOL.

Dr. Blaylock: My approach depends on the eyes. In cataract patients, I start with the eye that has the bigger cataract and implant either the SN6AD3 or the SN6AD1 as I described before. If the cataracts are equal in the two eyes, I implant the right eye before the left. For a simultaneous refractive lensectomy, I do the right eye first.

Dr. Faber: I do not think it matters which eye receives the lens first, but I would start with the IQ ReSTOR +3.0 D IOL.

Dr. Blaylock: In essence, I agree. I described my personal preference for implantation, but for most surgeons, the best approach may be to implant one eye with the AcrySof IQ ReSTOR +3.0 D IOL, wait 1 week, and then ask the patient how he likes his vision. If he is happy with it at all distances, then implant an IQ +3.0 D lens in the second eye. If he expresses a desire for sharper near vision, then present the option of putting the IQ +4.0 D lens in the second eye.

Dr. Ahmed: I agree with that strategy.

Dr. Rabinovitch: In my opinion, the AcrySof IQ ReSTOR IOL +3.0 D is the first lens on the market that gives the surgeon the confidence of being able to provide good near, intermediate, and distance vision with minimal patient complaints. I think we should reserve the +3.0/+4.0 D combination for high myopes who are used to precise vision or the odd occupational demand. Otherwise, I think bilaterally implanted IQ ReSTOR +3.0 D lenses are optimal.

LENS SELECTION

The AcrySof ReSTOR IOL +4.0 D

Dr. Ahmed: For what types of patients are we still using the AcrySof ReSTOR IOL +4.0 D?

Dr. Meyer: I implant the AcrySof IQ ReSTOR +4.0 D bilaterally in high myopes (> -4.00 D) and in patients who have macular degeneration and want strong near vision.

Dr. Hoar: We should ask presbyopes who have refractions of more than -5.00 D whether they take their glasses off to read. If they prefer to leave their glasses on, they may be more comfortable with the IQ ReSTOR +3.0 D lens.

Dr. Rabinovitch: It is critical to find out how the patient reads when considering which lens to give him. We must be careful to remind patients of all the daily activities they perform when asking them what range they prefer. Often, patients do not realize how much they rely on their intermediate range, and I am not convinced that older patients would be happiest with the IQ ReSTOR +4.0 D lens. If we can identify their preferred vision correctly, I think multifocal IOLs will benefit older patients a great deal more than we anticipated, because they will give these individuals the freedom to perform a range of tasks independently.

Dr. Meyer: I tell these patients that if they choose to receive the IQ ReSTOR +4.0 D lens bilaterally, they will either have to move the computer closer to view it or wear a +1.00 D add. I also ask the patient about his other daily activities and then use similar explanations to help him choose a lens.

Dr. Peters: The AcrySof ReSTOR +4.0 D IOL is an excellent lens, but for surgeons who are just starting to implant multifocal lenses and want the one that will give them the greatest patient satisfaction and the fewest complaints, I would recommend the IQ ReSTOR +3.0 D platform.

The AcrySof ReSTOR IOL +3.0 D

Dr. Ahmed: Let's talk about the AcrySof ReSTOR +3.0 D platform—to whom do you offer that lens?

Dr. Meyer: I suggest the +3.0 D lens bilaterally to patients who do not read a lot (and I recommend that surgeons who have not implanted AcrySof ReSTOR IOLs before to start with this lens). For patients who are not high myopes who do read a lot, I usually combine the ReSTOR +3.0 D and +4.0 D lenses.

Dr. Discepolo: My standard is to implant the IQ ReSTOR +3.0 D lens bilaterally, because it gives most patients the

best of all worlds. However, I will readily implant the ReSTOR +4.0 D IOL in patients who prioritize near vision.

Dr. Faber: No matter which ReSTOR lens you choose, you can be confident that your patient will be able to read uncorrected on postoperative day 1.

Dr. Blaylock: I agree. Overall, all combinations of the AcrySof ReSTOR IOLs—bilateral +3.0 Ds, bilateral +4.0 Ds, or the blended add—yield about the same rates of patient satisfaction. My early results have not shown a difference in the intermediate range between implanting the IQ ReSTOR +3.0 D bilaterally versus using the blended near add with the +3.0 D/+4.0 D combination. The benefit I have found with the blended add is a slightly closer range of near vision for patients who desire it. The caveat with using two different lenses, however, is that hitting the target refraction becomes more critical for both lenses.

INTERMEDIATE VISION: THE ACRYSOFT IQ RESTOR IOL +3.0 D VERSUS AN ACCOMMODATING IOL

Dr. Ahmed: During the past several years, patients who needed excellent intermediate vision have often received an accommodating IOL. Will the AcrySof IQ ReSTOR +3.0 D IOL change this paradigm?

Dr. Blaylock: The data are still early, but I am beginning to use the IQ ReSTOR +3.0 D IOL bilaterally in some patients who require excellent intermediate vision.

Dr. Peters: I am also beginning to use the IQ ReSTOR +3.0 D lens in patients in whom I previously would have implanted the Tetraflex.

Dr. Ahmed: I am finding similar results with the IQ ReSTOR +3.0 D IOL for intermediate vision. I tell my patients that they can also expect excellent near vision with this diffractive multifocal IOL.

IOL CENTRATION

Dr. Ahmed: Dr. Discepolo, would you like to address centration of the AcrySof IQ ReSTOR +3.0 D IOL?

Dr. Discepolo: When I first started implanting the ReSTOR +4.0 D lens, it was recommended to center the lens on the capsulorhexis. With nasalization of the pupil, however, the center of the lens would be slightly temporal. Now, I keep the microscope straight, and I ask the patient to look at the center of the light. Then, I align the Purkinje images until they match, which provides visual axis centration. Since

“I am beginning to use the IQ ReSTOR +3.0 D IOL bilaterally in some patients who require excellent intermediate vision.”

—John Blaylock, MD, FRCSC

doing this, I find that the lens is much better centered at 1 month, even with nasalization of the pupil.

Dr. Faber: This is not a big problem; Alcon lenses are known for not decentering.

Clinical Note: Diffractive multifocal IOLs are more forgiving of decentration (within 0.50 mm) than zonal refractive multifocal lenses. The reason for this is that shifts in centration change the relative areas of the optic between near and far distance viewing in zonal lenses.

IMPLANTING THE ACRYSOF RESTOR IOL UNILATERALLY IN A PATIENT WITH A MONOFOCAL IOL

Dr. Ahmed: How do you feel about implanting the IQ ReSTOR IOL in a patient who already has a monofocal lens in one eye?

Dr. Blaylock: I have no reservations about that; both the IQ ReSTOR +3.0 D and the IQ ReSTOR +4.0 D lens work well in this scenario. You just have to counsel the patient about the limitations of his vision between his two eyes. You cannot overpromise. I explain that he should have good vision in normal lighting conditions, but that he may need glasses at certain times. He may notice a little bit of glare and halos at distance, but then again, if he has had a cataract in the other eye, he may not see those symptoms.

Dr. Faber: When the ReSTOR +4.0 D lens first came out, I implanted it unilaterally in several patients who already had a monofocal IOL. I now try to dissuade patients from this combination, because I feel it degrades the performance of both lenses.

Technology Note: In Dr. Cionni’s bilateral AcrySof ReSTOR study, patient satisfaction was slightly higher with the bilateral implantation (8.9 compared with 7.3 out of 10 for the monofocal group), but the percentage of patients achieving 20/40 UCVA was very similar across the three groups (ReSTOR/phakic, ReSTOR/monofocal, and bilateral ReSTOR IOLs).⁴

FINAL THOUGHTS

Dr. Ahmed: Let’s each summarize our opinions about the AcrySof IQ ReSTOR IOL +3.0 D.

Dr. Discepolo: The IQ ReSTOR +3.0 D is the only lens that allows me to offer my patients unparalleled vision at both distance and near without any compromise at the intermediate distance.

Dr. Hoar: The IQ ReSTOR +3.0 D lens gives an improved range of vision at the distances that are most used for everyday activities.

Dr. Peters: The IQ ReSTOR +3.0 D IOL is one of the easiest and most predictable multifocal platforms to adopt and enhance a cataract practice.

Dr. Blaylock: The IQ ReSTOR +3.0 D lens is an important addition to the comprehensive refractive cataract surgeon’s arsenal.

Dr. Rabinovitch: The aspheric IQ ReSTOR +3.0 D IOL increased my practice’s rate of refractive lens implantations by tenfold in the space of only a few short months. My rates of postoperative *wow factor* and patient satisfaction have also soared. By week 1, my patients are extolling the virtues of this lens in the waiting room and in our lanes. As a result, my counselling staff are more confident than ever in the AcrySof IQ ReSTOR IOL. It has truly been the first multifocal lens that has given me the results I have been looking for.

Dr. Ahmed: What I love about the IQ ReSTOR +3.0 D lens is how the aspheric design gives a complete range of vision while maintaining excellent visual quality. This is the highest performing presbyopia-correcting lens for all lifestyle choices. ■

1. Discepolo MJ, Faber P. Clinical results of the ReSTOR® +4 add aspheric multifocal intraocular lens in Canada. Paper presented at: The XXVI Congress of the ESCRS; September 15, 2008; Berlin, Germany.
2. Faber P. Patient perceptions of the ReSTOR® +4 aspheric multifocal intraocular lens in Canada. Paper presented at: The XXVI Congress of the ESCRS; September 15, 2008; Berlin, Germany.
3. AcrySof® ReSTOR® Apodized Diffractive Optic Posterior Chamber Intraocular Lenses, Models MA60D3 and SA60D3 – P040020. <http://www.fda.gov/cdrh/pdf4/p040020.html>. Accessed May 21, 2009.
4. Cionni RJ, Osher RH, Snyder ME, Nordlund ML. Visual outcome comparison of unilateral versus bilateral implantation of apodized diffractive multifocal intraocular lenses after cataract extraction: prospective 6-month study. *J Cataract Refract Surg*. 2009;35(6):1033-1039.
5. Fonseca C. Comparative binocular defocus curves after contralateral AcrySof ReSTOR +3/+4 aspheric and bilateral ReSTOR +3 IOL implantation. Poster presented at: The ASCRS Symposium on Cataract, IOL and Refractive Surgery; April 3-7, 2009; San Francisco, CA.
6. Fonseca C. Patient perceptions and visual acuities after contralateral implantation of AcrySof ReSTOR aspheric IOLs SN6AD1 and SN6AD3. Paper presented at: The ASCRS Symposium on Cataract, IOL and Refractive Surgery; April 4, 2009; San Francisco, CA.
7. Suarez E. Comparison of bilateral implantation of ReSTOR aspheric SN6AD1 IOLs and contralateral implantation of ReSTOR aspheric SN6AD1 and SN6AD3 IOLs. Paper presented at: The ASCRS Symposium on Cataract, IOL and Refractive Surgery; April 4, 2009; San Francisco, CA.
8. Visual function with contralateral AcrySof® ReSTOR® aspheric SN6AD1 and SN6AD3. <http://www.clinicaltrials.gov/ct2/show/NCT00710905?term=NCT00710905&rank=1>. Accessed May 26, 2009.

