A COMPLETE GUIDE TO REFRACTIVE CATARACT SURGERY

GETTING STARTED WITH REFRACTIVE CATARACT SURGERY

BY JOHN A. HOVANESIAN, MD

It's what's best for your patients.

"ADOPTING REFRACTIVE CATARACT SURGERY DOESN'T MEAN SELLING YOUR PATIENTS MULTIFOCAL, ACCOMMODATING, OR TORIC IOLS. IT DOESN'T MEAN BUYING A FEMTOSECOND LASER AND PERFORMING LASER CATARACT SURGERY. IT DOESN'T EVEN MEAN LEAVING YOUR TRUSTY MONOFOCAL IOLS BEHIND. IT SIMPLY MEANS THAT, IN ADDITION TO CATARACT REMOVAL, PATIENTS ARE HELPED TO UNDERSTAND THE OPPORTUNITY TO CORRECT THEIR VISION AT THE SAME TIME AS CATARACT SURGERY."

All cataract surgeons in practice today should consider adopting refractive cataract surgery as an offering for every patient who is a candidate. In appropriate candidates, modern IOLs can achieve high refractive accuracy and spectacle independence that allow a nearly glasses-free life.

Adopting refractive cataract surgery doesn't mean selling your patients multifocal, accommodating, or toric IOLs. It doesn't mean buying a femtosecond laser and performing laser cataract surgery. It doesn't even mean leaving your trusty monofocal IOLs behind. It simply means that, in addition to cataract removal, patients are helped to understand the opportunity to correct their vision at the same time as cataract surgery.

So how does one get started with refractive cataract surgery, given that it requires more work and potentially a little more time counseling patients?

GET COMFORTABLE TALKING TO PATIENTS

The first step in beginning to offer refractive cataract surgery is getting comfortable talking with patients about the benefits, limitations, and costs. Having a conversation about paying extra for a better result than is typically achievable with the basic cataract surgery that is covered by insurance can feel awkward. However, that conversation must become as comfortable for doctors as the conversation they have with patients about the risk of retinal detachment after surgery—in fact, it is just as important and frequently more relevant to our patients than the discussion about retinal detachment.

When all the layers of refractive cataract surgery are peeled back, the conversation about cost is the biggest barrier keeping many surgeons from embracing this surgical mindset.

MASTER PATIENT CONVERSION TO PREMIUM IOLS

Looking to get started with refractive cataract surgery? It could be worthwhile to consider the following 10 strategies that have worked for our busy refractive cataract surgery practice.

- **No. 1: Believe in the technology.** In order to get patients on board with the thought of paying out of pocket for a premium IOL technology, you must recommend it enthusiastically. Any reservation in your voice will be apparent to patients, and their level of interest in that option will be affected.
- **No. 2: Understand the importance of the patient conversation.** For most patients, the costs involved in selecting a premium IOL are daunting. Take your time when discussing the available IOL technologies; rushing the process will prompt patients to opt out by default. It is also wise to avoid beginning the discussion by asking whether the patient is interested in a premium implant. Instead, explain the benefits of an advanced-technology IOL in terms understandable to every patient. Ask your staff to block off extra consultation time in the schedule for patients who are expected to be ready for cataract surgery so that you can have a productive conversation.
- **No. 3: Match the technology to the patient.** Having patients rate their visual disability and determine their needs for distance, intermediate, and near vision is extremely helpful. Use of a questionnaire helps to establish the patient's needs, but it does not substitute for asking directly what activities the patient enjoys. Thereafter, make sure to describe the benefits of what you have determined to be the most suitable implant for the patient in the context of his or her preferred activities.
- **No. 4: Leave the educating to the doctor.** Educational tools such as MDbackline (MDbackline), videos, consent forms, and your practice's website are invaluable, but I believe that the first verbal discussion about implant choices should be scheduled with the doctor in order to establish reasonable expectations. This strategy also allows the educational process to be customized to the patient's needs.
- **No. 5: Keep it simple.** A multitude of IOL options is available to patients, but don't just present a bunch of lenses. Make a recommendation of one implant that seems to fit that patient's needs and desires best; most patients feel it is the doctor's duty to make this choice.
- **No. 6: One size does not fit all.** Most patients will do some type of preliminary online research prior to their initial consultation. Therefore, it is not out of the ordinary for them to ask for a specific lens. If it is an appropriate choice, you can happily comply. If not, explain from your experience why their preference might fall short of their expectations.
- **No. 7: Counsel patients not to expect perfection.** Let them know that 90% of people can pass a driver's test without glasses after surgery, but they may need glasses to feel comfortable reading road signs at night. Likewise, tell patients to expect to need glasses for other tasks, such as for prolonged reading or for fine print.
- **No. 8: Be clear and unapologetic about extra costs.** Most patients don't know the cost of a premium IOL, and they are likely to be shocked by a four-digit price tag. Three strategies may soften this effect: (1) Take time to personally explain pricing to the patient rather than relying on a staff member to do so; (2) present the cost of the IOL in the context of the overall cost of cataract surgery, including anesthesia, the surgery center's fees, and the surgical fee itself; and (3) let the patient know that financing is available.
- **No. 9: Tell the patient what you would do for your own loved ones.** If you would honestly recommend a premium IOL to a loved one, end the discussion on this point.
- **No. 10: Follow up and follow through.** With premium IOLs, there are two crucial follow-up efforts after the consultation. First, at the end of your consultation, note in the chart how likely you believe this patient is to choose a premium lens. If you felt confident of a premium choice but learn later that the patient has chosen a monofocal, call the patient in an attempt to ensure that he or she has not based the decision on misinformation. Second and more important, do not wait for patients to complain. Contacting patients about 6 months after surgery can help to identify those who are beginning to develop posterior capsular opacification or who have a mild residual refractive error that is interfering with their spectacle independence. These marginally happy people may not be bothered enough to initiate a visit to your office, but they will tell their friends how disappointed they are with their expensive implants, which can damage your reputation. The final point to keep in mind when following up with patients is to consider scheduling a 6-month complete examination routinely for all premium IOL patients. If a patient is even mildly disappointed with his or her results, offer a no-charge enhancement or other treatment. Patients appreciate the extra effort and often tell their friends about it.

They feel that patients will expect more than they reliably can deliver, and they're uncomfortable with that change in focus.

How do you get comfortable talking to patients about the associated costs? First and foremost, remember that you are not *selling* anything. You are *educating* the patient about options. Share with them the available options long before you address pricing. In our practice, we use MDbackline (MDbackline), software that helps automate some of these conversations for doctors. Before every patient comes in to see us for a cataract consult, he or she receives contact from MDbackline with content that discusses what to expect from cataract surgery. That information also introduces the idea of lens implant options that cost extra but that give a lifetime of better vision without glasses.

Whatever form of supplementary patient education is being used, the idea is to give patients the tools they need to come to their first appointment well prepared. That way, the conversations they have with the doctor and the staff are easier—for them and for us. (For more tips on talking to patients about premium IOLs and mastering conversions, see the accompanying sidebar on this page.)

Another helpful strategy in getting involved in refractive cataract surgery is to first focus on correcting astigmatism, which does not have to be at a huge cost to the patient. Begin by performing free-of-charge limbal relaxing incisions, or offer the option of a toric IOL and charge only what the lens costs to the patient. Once you get comfortable handling those conversations with patients, you can progress to adding other forms of refractive cataract surgery—ones that sometimes require more sensitive discussions with patients regarding associated costs.

PICK YOUR PATIENTS WISELY

Hyperopes tend to be the happiest patients after refractive cataract surgery, so that is a good place to start. Target the ~2.00 D hyperope for the first handful of cases, and progress from there. Patients with low amounts of regular astigmatism and easygoing patients are also good test cases.

On the other hand, avoid patients who do not have realistic expectations for their postoperative vision. In fact, part of getting comfortable with refractive cataract surgery lies in the process of setting proper expectations preoperatively. And after surgery, it is helpful to remind patients of what you told them preoperatively about reasonable outcomes.

Select patients in whom you are sure you can nail the postoperative outcome perfectly. It helps if you have relatively consistent results in your standard cataract surgery procedures prior to segueing to refractive cataract surgery. It is therefore important to track your outcomes and to optimize your lens coefficients for cataract surgery. This should help to achieve a tighter spherical refractive result.

Along the same lines, it is crucial to use a modern IOL power calculation formula. The Holladay 2 and the Barrett Universal 2 are terrific. For unusual eyes, the Hill RBF is excellent, and for postrefractive surgery eyes, the Barrett True-K formula is remarkably accurate. Such formulas may take extra time to use, but most are built into modern biometry devices.

Lastly, remember that dry eye disease (DED) is probably the biggest enemy of accuracy in cataract surgery. Before treating any patient, regardless of whether or not you are undertaking refractive cataract surgery, make sure there is no sign of DED. If there is, treat the dry eye preoperatively and get it under control prior to any preoperative biometry. By taking the time and making the effort to screen for DED and select patients wisely, we can better control surgical accuracy.

CONCLUSION

Refractive cataract surgery is not a fad, and it does not necessarily require purchasing fancy equipment or selling patients on premium technologies and procedures. Refractive cataract surgery is an additional level of care that helps our patients achieve reduced dependence on corrective lenses to live the lives they want. ■

JOHN A. HOVANESIAN, MD
- Private practice, Harvard Eye Associates, Laguna Beach, California
- Clinical Instructor, UCLA Jules Stein Institute, Los Angeles
- Member, *CRST* Editorial Advisory Board
- drhovanesian@harvardeye.com
- Financial disclosure: Consultant (Alcon, Bausch + Lomb, Carl Zeiss Meditec, Johnson & Johnson Vision)