

THE PREMIUM IOL DECISION TREE

RED FLAGS FOR PREMIUM IOL CANDIDACY



Consider several important factors when identifying candidates for multifocal IOL implantation.

BY WILLIAM J. FISHKIND, MD, FACS

Evaluating a patient for possible premium IOL implantation launches a complex dialogue and decision. A key point to understand is that not all premium IOLs are created equal. I believe toric IOLs are in a different class than multifocal, trifocal, and extended depth of focus (EDOF) lenses. There are broader selection criteria for toric IOLs because there are more patients who are strong candidates for these designs and who will be pleased with their outcomes. Multifocal, trifocal, and EDOF IOLs, in my opinion, are best suited to a smaller patient population.

PATIENT EDUCATION

Ophthalmologists must discuss all premium IOL options with all patients before surgery and should also consider monovision as an option. Otherwise, an upset patient may return for a postoperative visit because he or she was not given a choice in the lens selection process and perhaps friends of theirs were. A surgeon should provide all patients with a list of choices and outline

why a particular lens is the most suitable option for them, whether it is a toric, multifocal, trifocal, EDOF, or monofocal lens. It is up to the surgeon to educate a patient about the most appropriate lens option based on data and surgeon experience.

During the informed consent process, the preoperative discussion covers the possibility of toric IOL rotation, potentially requiring further surgical correction 1 week after the initial procedure to reorient the IOL to the correct axis. Patients are also informed that roughly one in 2,000 patients cannot adapt to a multifocal, trifocal, or EDOF lens, in which case they may experience poor vision and request removal and replacement of the IOL. Patients must also understand that they may experience dysphotopsias such as halos around lights in the distance and that they may need glasses to read fine print and read in dim lighting with multifocal IOLs. They should also be informed that, if the power of the lens implant is incorrect, they may require an IOL exchange or a refractive enhancement with an excimer laser.

CONSIDERATIONS

I encourage my patients to avoid premium IOLs if they present with corneal pathologies such as significant dry eye disease or guttate, or significant posterior problems such as macular diseases.

IOL power calculations can be challenging for patients who have a history of refractive surgery, and a large angle kappa can be a source of IOL misalignment. The potential for vision loss in patients with diabetes, Fuchs dystrophy, early macular disease, and glaucoma requires consideration during the patient evaluation.

All patients should undergo preoperative macular OCT imaging and, if indicated, corneal pachymetry. Any abnormalities identified become factors in the assessment and advice to the patient.

Patients with severe intraoperative floppy iris syndrome or pseudoexfoliation syndrome are generally poor candidates for presbyopia-correcting IOL implantation. The surgeon's ability to perform anterior or posterior optic capture is mandatory for these cases. Yamane fixation or sulcus-sutured

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IOLs expand the selection pool, but, if poor capsular fixation or possible postoperative IOL decentration is probable, multifocal, trifocal, and EDOF IOLs should be avoided.

The patient's temperament is another consideration. Some patients are demanding and have unrealistic expectations prior to surgery. Others have obsessive-compulsive personalities

that cause them to fixate on a trivial flaw in the quality of their vision. These individuals are frequently despondent about their outcomes, demand an unreasonable amount of chair time, and can damage a surgeon's reputation. Even worse, they can talk other patients—some who may be excellent candidates for premium IOLs—out of the procedure.

CONCLUSION

In general, it is best to avoid presbyopia-correcting IOLs if there is *any* pathology in the visual axis or if there are meaningful signals that a patient's disposition is incompatible with the demands of the technology. Even when an outcome is excellent, these patients require more intensive postoperative care. Why look for trouble when ocular or psychologic pathology is identified? ■

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