I HAD CATARACT SURGERY, AND HERE'S WHAT HAPPENED

Adopting an advanced technology mindset.

BY MATTEO PIOVELLA, MD

I have always been an early adopter of IOL technologies. My belief is that, in order to have happy patients, you have to offer a variety of lens technologies that suit a variety of visual needs. Over the years, I have found that what can most effectively provide patients with the best range of vision is an advanced technology premium IOL, such as a bifocal, multifocal, or trifocal IOL. So, when I began to experience signs of a visually significant cataract, it was only right that I considered one of these types of lenses in my own eyes.

I decided to have cataract surgery because my myopia had increased from -4.00 to -9.00 D, a clear sign that the process of lens opacification had begun. Although my visual acuity was still good at the time—20/20 in certain conditions—I didn't want to wait for my cataracts to develop further. It is well known that denser cataracts are associated with an increased risk for complications. So, in July 2014, I submitted my eyes to cataract surgery.

TWO PROCEDURES IN TWO DAYS

My procedures were performed in Bochum, Germany, by H. Burkhard Dick, MD, PhD. Dr. Dick used the Catalys Precision Laser System (Johnson & Johnson Vision) to perform capsulorhexis and nucleus fragmentation. He implanted the AT LISA trifocal IOL (Carl Zeiss Meditec) in my right eye, and, the following day, the AT LISA trifocal toric IOL in my left eye. I calculated the powers of the IOLs myself and brought them with me in my luggage when I traveled to Bochum. Surgery was uneventful, but the entire surgical experience has made it easier for me to relate to the fears that patients have prior to the procedure.

My decision to have trifocal IOLs implanted in my eyes was neither brave nor difficult. It was made based on the practical, daily experience that I had accumulated from implanting multifocal and trifocal IOLs. I started to implant modern multifocal IOLs routinely in 2006 and trifocals routinely in 2013. Seeing the outcomes that can be achieved with these technologies made my own decision an easy one.

Now, after surgery, I no longer need glasses for driving or reading. In fact, I am completely spectacle-independent. I was able to drive my car on postoperative day 1, and I began performing cataract surgery using my OR microscope within 5 days after surgery. I had to wait 2 months for perfect vision stabilization due to a mild transitory cystoid edema, however. My ultimate postoperative outcome is plano in my right eye and 0.75 D of astigmatism in my left eye.

In 2014, around the time I had my own cataract surgery, I was implanting trifocal IOLs in about 40% of my cataract patients. Today, I implant trifocal IOLs in 90%. Even though my surgical experience is not the direct cause of the increase in trifocal IOL implantation, the fact that I chose this type of lens for both of my eyes makes it easier for me to explain to patients what they can expect after surgery. I always say to patients, "I have personally experienced cataract surgery and had trifocal IOLs implanted 5 years ago. My proposal is to implant the same artificial lens that provided me the opportunity to drive a car and read the newspaper without depending on spectacles."

I also believe that my decision to have trifocal IOLs implanted in my eyes serves as further evidence of my confidence in trifocal IOL technology, and I hope that it might encourage other cataract surgeons to embrace this technology.

ADOPTION OF TRIFOCAL IOL TECHNOLOGY

The majority of cataract surgeons practicing today do not implant multifocal or trifocal IOLs. Generally speaking, I think this is because surgeons feel that these IOL technologies are not capable of providing the same level of postoperative refractive results that monofocal IOLs can provide. Additionally, I think that there is a lack of accurate information available to cataract surgeons regarding how to properly implant multifocal and trifocal IOLs.

In my experience, trifocal IOL technology is the best way to address the individual needs of each patient

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presenting for cataract surgery and to provide good uncorrected intermediate vision without compromising near and distance vision. It is only right that I should follow the same advice that I give to my patients, which is, if they are good candidates, to elect for a trifocal IOL.

CONCLUSION

My cataract surgery dramatically improved the quality of my vision, and I have a new vantage point to share with my patients: I am a leading surgeon, and I have improved my vision with trifocal IOL technology. Now, when patients ask questions about the cataract surgery procedure or about trifocal lenses, I can draw from my own experience. I believe this helps to calm patients' fears, and it gives them more confidence in the whole surgical process. ■

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