NAVIGATING IOL CHOICES

With more options to choose from, how does a surgeon find the right mix of IOLs for their practice?

BY THILO SCHIMITZEK, MD, FEBOS-CR

The IOL landscape in Europe and other parts of the world is exploding. This is an exciting time for ophthalmologists because expanding IOL options provide more opportunities for us to help patients achieve visual outcomes that were not previously possible. Better vision at all distances, an increased chance of spectacle independence, a reduced risk of side effects, and the possibility of correcting presbyopia at the time of cataract surgery are some of the advantages associated with modern IOL designs.

Finding the right mix of IOLs for a practice, however, can be overwhelming, and selecting the right IOL for each individual patient can be a daunting task. Further, counseling patients on so many different IOLs can be arduous.

THE RIGHT MIX

It is inadvisable—not to mention impossible—for a single practice to stock all of the IOLs available on the market. As a result, surgeons must determine for themselves what the right mix of IOLs is for their patient base.

In my opinion, the best strategy for deciding which IOLs to offer is to choose two models at most from each IOL category (ie, standard and new-generation monofocal, multifocal/trifocal, and extended depth of focus [EDOF]). A good rule of thumb is to make sure that all of the IOLs selected complement each other.

Standard monofocal IOLs are still selected by many cataract surgery patients, and I recommend finding one model that can be a great fit for all patients. A standard monofocal IOL is an excellent choice in a variety of situations, including for individuals with clinical contraindications for premium IOLs such as early macular degeneration or corneal pathology. I also tend to select a standard monofocal IOL for patients who do not have strong feelings about achieving spectacle independence. Many patients are so used to their glasses that they can't imagine life without them.

Presbyopia-correcting IOL designs such as multifocal, trifocal, and EDOF can offer a significant advantage over standard monofocals if patients are willing to pay out of pocket for these implants and greatly desire reduced spectacle dependence after surgery. Offering a few of these lenses increases the likelihood of patient satisfaction after surgery because every patient has unique visual requirements.

IOL SELECTION

When selecting an IOL, I first ask myself, "Could the patient be interested in a lens with additional benefits compared to a standard monofocal IOL?" I then ask myself, "Are the clinical conditions of the eye suitable for a premium IOL?"

If the answer is yes to both of these questions, my next step is to

evaluate the patient's expectations and visual requirements. Learning how patients use their vision every day and finding out how comfortable they are wearing spectacles for certain tasks are crucial to IOL selection. The patient's profession and personal hobbies must also be considered. Bus and taxi drivers, for example, may be poor candidates for a presbyopia-correcting IOL because the potential risk of glare and reduced contrast sensitivity associated with these lenses might threaten their ability to drive at night.

Patients who require excellent distance vision for leisure activities such as hunting or playing golf tend to do fairly well with an EDOF IOL if they are willing to wear spectacles for near vision tasks such as reading. Modern EDOF lens models offer a high degree of spectacle independence, particularly for daily activities such as reading a computer/laptop screen, smartphone, GPS device, or price tags. Compared to a monofocal IOL, there are fewer trade-offs with EDOF IOLs because they have a larger landing zone. Most patients accept that they will occasionally need to use reading glasses to achieve excellent distance and good intermediate vision. The crucial thing is that they understand that multifocality is associated with optical side effects.

Many patients are excellent candidates for trifocal IOLs. These individuals include those who regularly participate in sports and outdoor activities and those whose jobs require a lot of computer work. Currently, these lenses are popular with my patients because there is a high probability of spectacle independence at all distances. There is one caveat: Patients must understand that their brain will require time to adapt to their new visual system.

Lastly, newer monofocal IOL designs, which some refer to as *monofocal plus*, can also be considered. I, however, prefer multifocal and EDOF IOLs because I find that they offer exceptional patient comfort and a low risk of optical side effects. I may consider a monofocal plus lens if patients have limited funds or their ocular anatomy is not suitable for a premium IOL. I am in the process of adding this new type of lens to my portfolio.

PATIENT COUNSELING

It is the surgeon's responsibility to counsel patients using accessible language and to decipher the complicated topic of IOL selection in a way that helps patients understand the pros and cons of each option. Furthermore, patients should not feel that a monofocal IOL is a cheap or suboptimal solution. For many patients, a standard monofocal is an inexpensive way to achieve quality vision at one or more distances (eg, with monovision). Individuals who are interested in greater spectacle independence should have the opportunity to consider a premium IOL. Sensitive communication is key to delivering excellent outcomes without making patients feel forced into a decision.

Describing a variety of IOL models to patients requires considerable chair time, but I find that they value the extra attention. Meticulous patient management is rewarded with high patient satisfaction, and it can foster better relationships with patients and more patient referrals.

In my department, an estimated 99% of patients who ask for a premium IOL are referred to us by former patients. Our patients are our ambassadors because they are so happy about and grateful for their vision.

Surgeons should, in my opinion, embrace the possibilities that new IOL technologies offer. It is a rewarding process to help patients find the solution that fits them best. ■

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