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Assessing the Safety & Efficacy of Presbyopia-Correcting IOLs

Announcer:

You're listening to *Eye on Ocular Health* on ReachMD, and this episode is part of our "Clinical Minute" series. Here's your host, Dr. Neda Shamie.

Dr. Shamie:

In this "Clinical Minute," we'll be discussing a review of the published literature assessing the safety and efficacy of presbyopia-correcting IOLs. Dr. Julie Schallhorn is here to discuss the findings.

Julie, thank you so much for being here, and more importantly, for your contributions to our field and our understanding of advanced technology lenses. I'd love to hear your thoughts on your paper and just a few pearls on what you found and how we can apply it to our practice.

Dr. Schallhorn:

Yeah, thanks so much for having me.

You know, this was a big effort that we undertook as part of the Academy Committee on Ophthalmic Technology Assessments and looked at every single paper that has been published basically about the lenses that are currently approved in the United States, and looked at the findings in terms of vision and in terms of quality of vision.

Basically, the findings can really be boiled down into three main points. Number one, advanced technology lenses that are intended to correct presbyopia do give patients an extended range of vision as compared to a monofocal IOL. So you're going to be able to see at distance and at varying points up close. The near vision is dependent upon the design of the lens, of course. The other major finding in the paper is that, you know, these lenses, by and large, all induce more photic phenomena than the monofocal control lenses. So patients, you know, are more likely to have things like starbursts, glare, ghosting, halos at nighttime. The degree, we can't compare between lenses, because there's not really a great measure that can be applied across all the lenses right now. And the third finding is that these lenses do affect contrast sensitivity, particularly low light conditions. It's difficult to kind of suss out the clinical relevancy of that, but it was another finding. And it does mean that you shouldn't put these lenses in patients that already have reduced contrast sensitivity for other things like retinal diseases or, you know, glaucoma advanced glaucoma, severe corneal diseases.

Dr. Shamie:

So like we are seeing in our practice, it definitely adds a level of independence from spectacles across the board, depending on the, like you said, the lens technology and lens style and design, with the caveat that the patient needs to be more forgiving about the photic phenomenon. How would you present this to your patient then?

Dr. Schallhorn:

You know, I like to talk to patients and say, you know, what are your goals after cataract surgery? You know, what do you want to be able to do? Do you want to wear glasses? Some people are used to it. Or do not want to wear glasses? If you don't want to wear glasses, where do you want to not wear glasses? Is it here, up here? Or is it you know, you're looking at your iPhone when you're out at a restaurant? You know because those are different visual needs.

Once I have an understanding of their visual needs and kind of their general like, you know, ocular health, then I say, 'Okay, you're a candidate for lenses, A, B, and C.' A is a monofocal, you know, or a toric, you know, depending upon their sight, you know, B would be an EDOF lens, and C would be a trifocal lens. 'And with our lenses, there's always a little bit of trade-off, I can't give your eyes back like you were when you were 20 years old, unfortunately. And what makes sense in this trade-off for you? You know, is it like you're okay

with a little bit of photic phenomena at nighttime, and you've got this incredible, like range of vision? Or you know, do you just never want to see floating phenomena at all, and you're okay with glasses?' And once you present it to people that way, usually they're able to kind of self-select into what is important for them.

Dr. Shamie:

There's no question that the latest generation of these lenses have improved in their photic phenomena compared to prior generations. As a surgeon, I feel more confident presenting them to my patient. And in many ways, when a patient has moderate or advanced cataract, I know that the photic phenomena is going to be better than what they're experiencing and what brought them in. And so again, with great confidence, given the high quality of vision that they're getting, even with the photic phenomena, in my practice, at least I'm seeing a much higher rate of conversion.

Dr. Schallhorn:

Oh, yeah, exactly. Because I think that, you know, we're able to say, you know, photic phenomena, especially these first-generation lenses were, like, fairly distracting for a lot of people. And I think we've become more understanding of the role of the photic phenomena and also the causes of it. We are much better at, A, making sure the patients have, you know, all the components of things that reduce the risk of getting photic phenomena, you know, a healthy ocular surface, good lid closure, you know, smooth epithelium, a good tear film. And then, B, just with this lens design, I think that you know, we are seeing kind of, you know, kind of the best optical profile possible.

Dr. Shamie:

Absolutely. Thank you so much for this summary, and I look forward to reading your paper in greater detail.

Dr. Schallhorn:

Thanks so much for having me.

Announcer:

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