

EVOLVING STANDARDS

in Optometric Cataract Care

An in-depth roundtable discussion on how new technology is driving change in optometry.

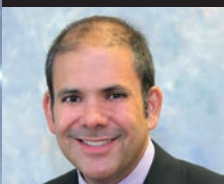
EVOLVING STANDARDS

in Optometric Cataract Care

FACULTY



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David Geffen, OD, is in group practice at Gordon-Weiss-Schanzlin Vision Institute, where he specializes in family eye care, contact lenses, low vision and refractive surgery consultation.



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Change is a Necessity

Paul M. Karpecki, OD: The number of Americans with age-related eye disease and the vision impairment that results is expected to double within the next three decades.¹ Research indicates that between the years 2013 and 2019 alone, we can anticipate a 17% increase in the projected number of cataract procedures.² Should optometrists brace themselves for big volume increases?

Marc R. Bloomenstein, OD: Yes, perhaps even more than these numbers suggest. These figures—though staggering—are predicated on the notion that older patients need cataract surgery. The fact that more and more patients are starting to look at lens procedures the minute they develop cataracts (or sooner) means that the number of surgery-ready patients we see in our offices could be even higher.

Dr. Karpecki: Why do you think so many patients are seeking cataract surgery at an earlier age? Is it exclusively demographics and word of mouth?

David Geffen, OD: When I got into practice 30 years ago, it was rare to see nuclear sclerotic changes in a 55-year-old. Today I don't have a 55-year-old in whom I haven't seen some nuclear sclerotic change. I'm seeing cataracts in a much younger population today.

Dr. Karpecki: We see that in our practice as well. Clearly, the demand for surgical eye procedures

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is increasing. However, the number of practicing ophthalmologists is expected to remain flat.³ For every surgery there are at least three or four exams. Now consider the surgeon's predicament. The capacity to do three or four times what they're doing is going to be quite difficult.

Dr. Geffen: Indeed. The ophthalmologists who aren't currently working with optometry are going to have to because good surgeons will be so busy that they will not be physically

"Today's cataract surgery is refractive surgery and we should approach it as such."

– Chris Freeman, OD

able to handle the postop care for these patients.

Dr. Karpecki: Will optometrists need to alter their current comanagement roles?

Chris Freeman, OD: Absolutely. The hands-off approach option won't exist to the same degree that it does now because the number of patients will be too high. We can't choose to let the surgeon's office handle everything. We have to play a larger role.

Dr. Geffen: Historically, a lot of ODs have avoided this because there's a perception it's not worth our time. Certainly, 20% of a Medicare fee for assuming three months of care hardly seems worthwhile. Fortunately, premium lenses have increased the amount that the OD is reimbursed, making it worth our time.

Jim Owen, OD: Learning how to shoulder this added responsibility is going to take time. I advise ODs to start preparing now so they won't be overwhelmed when these patients start flooding our offices. See what works and what doesn't. Find a good surgeon. Build your knowledge and refine your skills.

Dr. Geffen: Another thing to keep in mind is that comanaging cataract builds patient loyalty. In most cases, patients are extremely happy once

details to help them choose the right procedure—whether that's a toric IOL, a multifocal or a conventional lens. This is becoming a necessity.

Dr. Owen: We have a much bigger responsibility. Gone are the days of, "You have a cataract; go see the surgeon."

Dr. Karpecki: Is this a result of higher patient expectations or is it about improved technology?

Dr. Bloomenstein: Both. We live in a day and age when people can go in and have a cataract removed within 15 to 20 minutes, and then walk out of the surgery center with improved vision and quality of life. Many are able to function at all distances without glasses. When a patient meets someone who's had this done, they get excited. Their personal expectations are higher. They want and need to be educated about premium options.

Dr. Freeman: Today's cataract surgery is refractive surgery and we should approach it as such—even when the lens is not fully ripe. The expectations of seeing well are extremely high. Active adults have lower tolerances for any reduced quality-of-life issues resulting from impaired vision from early cataracts. For these presbyopes, a lens-based procedure may be more appropriate and is certainly worth discussing.

Provide Informed Consent

Dr. Karpecki: Are we falling short in our role as primary care providers if we fail to engage cataract patients in a discussion about all of their options?

they've had surgery. They have many years of life ahead of them. By playing an active role in their cataract care, we can keep these patients in our practices.

Defining New Standards of Care

Be Aware of Expectations

Dr. Karpecki: From a standard-of-care perspective, do recent advances in cataract surgery technology, such as lasers and premium intraocular lenses (IOLs), make it necessary for optometrists to change their preoperative consultations with cataract surgery candidates?

Dr. Geffen: Optometrists are going to have to play a role preoperatively. We haven't given our patients the

EVOLVING STANDARDS in Optometric Cataract Care

Emerging Technology Notice

As optometrists, one of the most important things we can do for ourselves and for our patients is to stay abreast of the new technology that is rapidly becoming available. It's imperative that we have a working knowledge of the intraocular lenses (IOLs) that our patients are discussing with their friends and their surgeons.

One of the most recent innovations in cataract care is the addition of two new TECNIS® Multifocal IOLs (Abbott Medical Optics Inc.). Until recently, the TECNIS Multifocal IOL was available only in +4.00. The +4.00 lens provides a full range of outstanding vision and is designed for patients who favor near vision-related activities, such as reading.

The new TECNIS Multifocal IOLs are designed for patients with slightly different preferences. A new +2.75 lens is intended for patients who favor intermediate vision activities, such as golfing or grocery shopping. The new +3.25 lens is designed for patients who prefer activities at longer reading distances, such as multimedia work. Like the +4.00 lens, both of these new designs continue to offer a full range of outstanding vision. In fact, more than 80% of patients with bilateral implants reported an ability to function comfortably without glasses at all distances when implanted with the two new TECNIS Multifocal IOL designs. Furthermore, more than 93% of these patients say they would elect to have the same IOL implanted again.¹

With each new innovation in IOL technology, comes the ability to better treat patients. It's incumbent upon us as primary care providers to guide our patients toward the choice that best suits their individual needs. As their optometrists, no one knows these visual needs better than we do. This truly is an exciting time for us as well as the patients we serve.

INDICATIONS: The TECNIS® Multifocal 1-Piece intraocular lenses are indicated for primary implantation for the visual correction of aphakia in adult patients with and without presbyopia in whom a cataractous lens has been removed by phacoemulsification and who desire near, intermediate, and distance vision with increased spectacle independence. The intraocular lenses are intended to be placed in the capsular bag.

WARNINGS: On rare occasions, the visual effects perception of halos/glare around lights may be significant enough that the patient will request removal of the multifocal IOL. Contrast sensitivity is reduced with a multifocal lens compared to a monofocal lens. Therefore, patients with multifocal lenses should exercise caution when driving at night or in poor visibility conditions.

See Important Safety Information continued on page 11.

1. Abbott Medical Optics Data: DFU, TECNIS® Multifocal 1-Piece IOL, Models ZKB00 and ZLB00, and DFU, TECNIS Multifocal 1-Piece IOL, Model ZMB00.

Dr. Owen: Yes, I think we are falling short. Newer lenses and lasers have created an outstanding opportunity. Patients deserve to be made aware of these options. A few years ago, a patient of mine brought her mom in because (as she described it), "her eyes had been ruined by cataract surgery." In reality, it was a perfect cataract surgery. However, the patient lost her near vision and—since no one had explained this ahead of time or presented a multifocal lens option—the patient thought everything went wrong.

Dr. Bloomenstein: I was involved in a similar case where a patient felt that the standard of care was breached because the surgeon didn't talk to them about putting in a multifocal. If we fail to give patients all the information and deny them the opportunity to make their own informed decisions, then we are not true patient advocates.

Dr. Freeman: True informed consent requires that the patient be fully informed. This includes lens technology as well as femtosecond laser technology.

Dr. Geffen: Optometrists are the gatekeepers of their patients' care. Typically, we've had that patient in our practice for many years. We have the knowledge of their lifestyles and how their vision correction has been over time. If my patient has been wearing monovision contacts for the last 15 years and the cataract surgeon uses a distance lens, my patient will be very unhappy—and that would be my fault for not communicating

with the surgeon. The same could happen with a patient who wears a multifocal contact lens. It's the optometrist's job to spend the time educating the patient and then informing the surgeon of the patient's history.

Consider Quality of Vision

Dr. Karpecki: When do you begin discussing cataracts with your patients?

Dr. Bloomenstein: I begin the discussion as soon as I start to see some nuclear changes or some peripheral cortical changes. I explain that the vision is changing because the lens is changing, and I let the patient know that we can try to keep meeting the changing visual needs, but we're going to get to a point where we can't.

Dr. Karpecki: Do you perform any additional testing at this early stage?

Dr. Bloomenstein: I do. Sometimes just looking at Snellen acuity or just doing a refraction isn't enough. Getting a patient to 20/20 doesn't mean that patient has the best quality of vision. I test for brightness acuity and contrast.

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Dr. Geffen: Quality of vision is very important and you don't need sophisticated tests to see how it impacts a patient. You can ask the patient whether he sees any halos or glare driving at night. If they say yes, take out your penlight and ask him, "What do you see?" If he sees a glow around it, he has halos. Quality of vision is key and it doesn't cost a penny to test for it.

Modern Cataract Surgery Technology

Multifocal IOLs

Dr. Karpecki: We've established that educating patients on the benefits of multifocal IOLs is a necessary component of the informed consent process. But, how in depth should this conversation be, and at what point should optometrists turn the conversation over to a surgeon?

Dr. Freeman: I talk to the patient about their goals and their visual demands. Based on that, I make a recommendation that I think a presbyopia-correcting IOL would be a good option. However, I leave it a little open-ended so that, if a surgeon has a different opinion for some reason, the patient won't doubt the surgeon.

Dr. Geffen: This is where communication and knowing your surgeon is critical. You need to know the philosophy of the surgical center that you are working with; and you need to know the kinds of lenses that it uses and in which patients they are used. I tell the patient that he's a great candidate for a presbyopia-correcting lens, but I add that the final decision will be made when the surgical center takes measurements. A final and critical piece of this puzzle is the communication that the OD sends to the ophthalmologist, which should include a history and notes regarding why the OD thinks a particular lens might be appropriate.

Dr. Owen: I've found it's effective to give the patient something to walk away with. For example, I might say, "Make sure you ask the surgeon about a TECNIS® Multifocal." Then, I write it down on the back of my business card and hand it to the patient. Since I have a good relationship with my surgeon, he knows this cue means I've had the initial discussion with the patient about the TECNIS Multifocal, which is a time-saving benefit for the surgical center.

Dr. Karpecki: Discussing multifocal IOLs doesn't only benefit patients and surgeons—it's good for the OD as well. If a patient shows up at a surgical office and no previous mention had ever been made of these newer technologies, the patient comes to one of two conclusions: either the technology isn't that good or the optometrist isn't that knowledgeable. A proactive discussion prevents the patient from coming to either erroneous conclusion.

EVOLVING STANDARDS

in Optometric Cataract Care

Toric IOLs

Dr. Karpecki: If a patient with 1.50D of cylinder presented to his optometrist wanting soft contact lenses, the OD

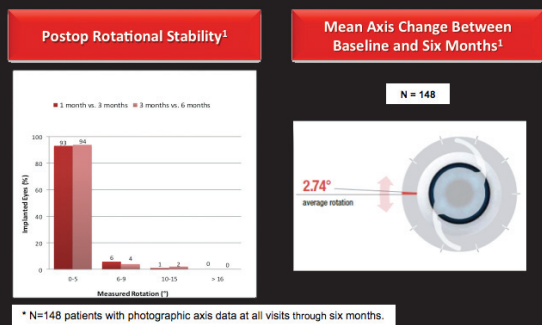
would almost certainly try a toric contact lens as opposed to a monofocal or multifocal lens that didn't address the astigmatism. Shouldn't this same standard apply when recommending an IOL?

Dr. Geffen: This is where optometry has really lost itself. We wouldn't hesitate to correct the astigmatism in a soft toric or in glasses. We don't leave cylinder out. This standard should apply to IOL recommendations.

Toric IOLs: What You Need to Know

Approximately 37.7% of patients with cataracts have more than 1.00D of preexisting corneal astigmatism. In fact, toric IOLs represented a potential market of approximately 268,000 procedures in 2014 alone¹ and is a fast-growing segment of the premium IOL market over the course of the last three years.² The TECNIS[®] Toric features a special TRI-FIX 3-Point Fixation. An offset haptic design enables the lens to adhere to the posterior capsule. This provides constant capsular contact and additional stability over traditional single-piece lenses. The TECNIS Toric IOL meets ANSI standards, exhibiting high postoperative rotational stability. In fact, 94% of eyes implanted with TECNIS Toric IOLs had a change in axis of $\leq 5^\circ$ between two consecutive visits approximately three months apart.³

TECNIS Toric IOL Meets ANSI Standards*



* N=148 patients with photographic axis data at all visits through six months.

INDICATIONS: The TECNIS[®] Toric 1-Piece posterior chamber lens is indicated for the visual correction of aphakia and pre-existing corneal astigmatism of one diopter or greater in adult patients with or without presbyopia in whom a cataractous lens has been removed by phacoemulsification and who desire improved uncorrected distance vision, reduction in residual refractive cylinder, and increased spectacle independence for distance vision. The device is intended to be placed in the capsular bag.

WARNINGS: Rotation of the TECNIS Toric 1-Piece IOL away from its intended axis can reduce its astigmatic correction. Misalignment greater than 30° may increase postoperative refractive cylinder. If necessary, lens repositioning should occur as early as possible prior to lens encapsulation.

PRECAUTIONS: Residual viscoelastic and/or over-inflation of the capsular bag may allow the lens to rotate, causing misalignment of the TECNIS Toric 1-Piece IOL with the intended axis of placement.

See Important Safety Information continued on page 11.

1. Market Scope, 2013 Comprehensive Report on Global IOL Market.
2. Market Scope, 2013. Ophthalmic Market Perspectives.
3. TECNIS Toric 1-Piece IOL [package insert]. Santa Ana, Calif: Abbott Medical Optics Inc.

Dr. Karpecki: How can optometrists effectively convey the visual benefits of toric IOLs to their cataract patients?

Dr. Bloomenstein: Patients don't know what they don't know. They just know they can't see. I tell patients that astigmatism is what causes them to experience the bit of doubling that they see, as well as the lack of sharpness in their vision. Then I explain that a toric IOL can correct that.

Dr. Freeman: I keep it simple. I say, "We are going to correct your distance vision so you can see well." This conveys the visual benefit.

Dr. Geffen: Patients know they have astigmatism and they know they don't want that "disease." They think astigmatism is some weird thing and they don't like it. They're open to anything that will get rid of it.

Dr. Karpecki: This brings up the issue of cost. Obviously a toric IOL has a premium price tag.

Dr. Freeman: We shouldn't make assumptions about what patients may or may not be willing to pay. The toric contact lens is a great example for optometry. We prescribe a toric contact lens knowing it's going to cost more—that doesn't stand in the way of our recommendation. We should prescribe what's right for the patient

and not presume what patients may or may not be willing to pay for.

Dr. Geffen: In our practice, toric IOLs are the easiest thing to talk to our patients about, and they are the premium item patients are most likely to fund. Patients who I least expect will somehow come up with the money or take out a Care Credit and pay it over time.

Dr. Karpecki: Based on their readiness to pay an additional fee, it's obvious that patients recognize the value of toric IOLs preoperatively. But, what about postoperatively? How do toric IOLs affect patient satisfaction?

Dr. Bloomenstein: Astigmatism induces double vision and has an overall debilitating effect on both near and distance vision. Patients are elated when they no longer

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— Marc R. Bloomenstein, OD

have the burden of that blurred vision. I see this most when patients can go and get a pair of non-prescription sunglasses instead of having to be reliant on a pair that also corrects their astigmatism. It's the little things that really make a difference for patients.

Dr. Geffen: Our most happy patients are the toric IOL patients. They have exceptional distance visual acuity and are very happy with their decision to proceed with surgery. These patients enjoy telling their friends about their results and refer more often than conventional patients.

Dr. Freeman: A patient's visual outcome is paramount to feeling the surgery was successful. Expectations are an important part of this. If a patient is led to believe that distance vision will be sharp after surgery, then not correcting for astigmatism will result in blur and a dissatisfied patient from failure to meet expectations. In many cases, even with discussion of appropriate expectations, patients may have higher expectations than they should. In that case, blurry vision, due to uncorrected astigmatism, can undermine an otherwise successful surgery that is on

par with the preoperative discussion of postoperative expectations.

Femtosecond Lasers

Dr. Karpecki: We've established that it's best to discuss premium IOL options early on in the disease

Femtosecond Technology: What You Need to Know

One-third of U.S. cataract surgeons either currently offer or plan to offer femtosecond laser cataract within the next 12 months, with an additional 21% saying they are waiting for more information before making specific plans.¹ The CATALYS® Precision Laser System (Abbott Medical Optics Inc.) creates precise incisions in the cornea and lens. The laser can segment and completely soften the nucleus. Because the lens is softened, the surgeon can perform a fluidics-driven method of lens extraction, ultimately resulting in minimal corneal swelling² and inflammation postoperatively.³

INDICATIONS: The OptiMedica® Catalys® Precision Laser System is indicated for use in patients undergoing cataract surgery for removal of the crystalline lens. Intended uses in cataract surgery include anterior capsulotomy, phacofragmentation, and the creation of single plane and multi-plane arc cuts/incisions in the cornea, each of which may be performed either individually or consecutively during the same procedure.

PRECAUTIONS: The CATALYS® System has not been adequately evaluated in patients with a cataract greater than Grade 4 (via LOCS III); therefore no conclusions regarding either the safety or effectiveness are presently available.

See Important Safety Information continued on page 11.

1. Market Scope Q2-2104 Survey of US Cataract Surgeons.

2. Conrad-Hengerer, Ina et al. Corneal endothelial cell loss and corneal thickness in conventional compared with femtosecond laser-assisted cataract surgery: Three-month follow-up. JCRS. Volume 39(9):1307-13.

3. Abell, Robin G. et al. Anterior chamber flare after femtosecond laser-assisted cataract surgery. JCRS. Volume 39(9):1321-26.

EVOLVING STANDARDS in Optometric Cataract Care

process. Do you discuss a femtosecond laser option at this time as well?

Dr. Owen: Yes. You don't know what the patient's experiences are with cataract surgery. They might remember a parent who spent a week in the hospital with sandbags at the side of their head. Explaining the femtosecond laser procedure is a great opportunity for me to set the stage of where the technology is today.

Dr. Freeman: I like to mention it as soon as I talk about cataracts in general because I'm excited about the femtosecond laser assisting with cataract surgery. I've been extremely pleased with the results and our patients and referring doctors are excited that we offer outstanding technology for patients.

Dr. Bloomenstein: I find that many patients assume that the surgery is performed by a laser anyway. It puts me in a difficult position if I have to backtrack and explain that the surgeon will be using a blade. By making femtosecond laser technology part of my initial discussion, I set the stage that the technology today is everything that the patient probably thought it was.

Dr. Geffen: I practice under the assumption that every patient should get the best care. I believe femtosecond cataract surgery is outstanding. I talk about this with the patient and I explain how safe and effective it is. Never assume that a patient doesn't want what's best for his eyes. If a patient doesn't want to get the best, he will tell you. But don't deny him by failing to educate.

Prepare the Ocular Surface

Dr. Karpecki: Do we need to pay closer attention to ocular surface health in patients who show interest in modern cataract technologies and procedures or any cataract surgery candidates for that matter?

Dr. Owen: It really doesn't matter how good the lens is—if a patient has an unhealthy ocular surface, it will affect the outcome. We need to get the tear layer as good as it can get—just as we do with refractive surgery patients. This is part of the new preop comanagement regimen that optometrists need to take ownership of.

Dr. Geffen: I agree. This is a critical piece of the comanagement relationship. The patient should have a pristine ocular surface before they're referred to the surgery center. Otherwise, it makes for a very difficult tap dance at the center. The patient can lose confidence in the optometrist if the surgeon has to send him back. The patient will wonder why you didn't take care of it in the first place.

Dr. Bloomenstein: Optometrists also need to be alert to the fact that, even though ocular surface disease can be asymptomatic, it matters preoperatively.

Dr. Freeman: Ocular surface health also plays a role postoperatively. Part of our responsibility is to let patients know that they'll have some dryness after surgery, and that it may cause some visual fluctuation. Build confidence by educating the patient and setting the expectation that this is a normal side effect that you can minimize by beginning ther-

apy right away. Let the patient know that you want to optimize the ocular surface first and then continue after surgery to ensure the best recovery for their vision. We feel this is an extremely important part of today's refractive cataract surgery and ask our referring optometrists to begin treatment to optimize the ocular surface as soon as they recognize the patient needs to be referred for surgery.

Dr. Karpecki: Can poor ocular surface health have a negative impact on biometry accuracy and IOL calculations?

Dr. Freeman: Between advanced technology IOLs and advances with femtosecond lasers, we have wonderful technology. But, as good as that is, a poor ocular surface can tear down all those benefits and make for a poor patient experience with less-than-optimal results because of its adverse effect on biometry and subsequent outcome on postoperative vision.

The Comanagement Relationship

The Foundation

Dr. Karpecki: A good comanagement relationship is built on trust, mutual respect and good outcomes. If your surgeon is delivering these three things, does it really matter if he or she doesn't offer the latest technologies in cataract surgery and IOLs?

Dr. Freeman: It absolutely does matter. In today's information-savvy world, patients are doing lots of online research. They're also talking to their friends who've already had

surgery. Many patients are aware of some of the options that are available. If they go to a surgeon to whom you referred them and that surgeon doesn't recommend the option that they know is available, they may not trust your referral.

Dr. Bloomenstein: The communication about the latest technology has to happen. Without it, there can be no trust or mutual respect.

Dr. Karpecki: Similarly, if a surgeon does not offer the latest technologies to appropriate patients, I'm not sure he or she can deliver the best outcomes.

The Selection Process

Dr. Karpecki: How do you select a surgeon? Is there a vetting procedure that you follow? What, specifically, should you look for?

Dr. Owen: I recommend taking your surgeon to lunch. It will help you determine whether you are comfortable having a frank con-

versation with him or her. There shouldn't be any awkwardness. Also, always ask, "If something goes wrong or I have a question, how do I get a hold of you?" How the surgeon answers this question speaks volumes. If the surgeon says, "Well, I have the service to take calls," I would personally move on. But if he

hands you his cell phone number, you're off to a great start.

Dr. Bloomenstein: I also want to know what the patient experience is like. Ask the surgeon to explain what the process is for the patient. At what point do they start talking about the different lenses? At what point do they provide financial information? What is their philosophy about follow-up and comanagement? These are important questions. I also suggest a little private detective work. Call the office as if you were a patient trying to get a hold of the surgeon and see what your patients will have to go through to get their concerns addressed.

Working Together

Dr. Karpecki: Once you've identified a surgeon whose philosophies match your own, how do you build and maintain a strong relationship?

Dr. Owen: One of the simplest things is to let the surgeon know when you've seen the patient back. They want to

know whether the patient is doing well, so send a quick note to the surgical center to follow up.

Dr. Geffen: I encourage optometrists to spend one day watching surgery and seeing postops at the center. This enhances the overall process because it helps you understand exactly what the patient is going through and what the surgeon prefers in a postop experience.

Dr. Karpecki: When you spend a little time at the surgery center, you pick up some very valuable clinical insights—after all, they see these cases all day, every day. In addition, you get a good sense of how things are stated to the patients. These communication cues can be very helpful because knowing this allows you to deliver a more consistent message, which appears more seamless to the patient.

Postoperative Care

Establish Protocols

Dr. Karpecki: What are the key elements of an effective postoperative care protocol?

Dr. Geffen: To start, I would encourage ODs to call their patients the night of the surgery to see how they're doing. This strengthens the bond.

Dr. Freeman: Simple, effective communication is key in optometric comanagement. Protocols should be written down. The optometrist and the surgeon should use the same one-page document outlining the patient's do's and don'ts, restrictions, medications, etc. Everyone should be on the

**"Simple, effective communication is key in optometric comanagement."
— Chris Freeman, OD**

know whether the patient is doing well, so send a quick note to the surgical center to follow up.

Dr. Freeman: As optometrists, we want our patients to come back. Surgeons, on the other hand, simply want to know if the patient is doing well—so let them know. It's a profes-

EVOLVING STANDARDS

in Optometric Cataract Care

same page—literally. The surgeon's office should send a faxed copy of the patient's postop instructions to the optometrist immediately after the procedure so he or she knows exactly what the patient should be doing postoperatively and if there are any special, individual circumstances or instructions for that particular patient.

Dr. Karpecki: It's also important for the surgeon to instruct the patient to bring their drops with them to the follow-up visit. This is one way we can be sure that they filled the prescription, received the right drops, and are using them properly. Some patients see the price tag and don't even get the medication and are afraid to mention it, when we could have easily offered alternative treatment options if we'd known.

Dr. Bloomenstein: An effective protocol should also include a greater understanding of the norms. There are several things that surgical centers see routinely in the postop period that would alarm a doctor who isn't seeing that volume. For instance, the red hue that patients may see from the anesthesia or pressures mid 30s. The surgeon should go through these things with the optometrist so patients aren't sent back to the surgery center when they don't need to be.

Communicate with Confidence

Dr. Karpecki: If you see something that's not a typical postoperative finding, what's your next step?

Dr. Geffen: The OD should feel free to call the surgery center and talk to the surgeon or an optometrist who works in that center at any time.

Dr. Owen: The surgery center sees a lot more than most optometrists do. They're used to seeing things that an OD might think is a little off. Nine times out of 10, a phone call will clear everything up and the OD will benefit from the education.

Dr. Geffen: If you lack the ability to communicate with the surgeon, you run the risk that your patient will doubt your knowledge. If you think something is a big deal, and you send the patient back to the center where he is told it's a common and very minor thing, the patient will lose confidence in you. To make comanagement work well, you have to communicate.

Repeat Preop Messaging

Dr. Karpecki: When patients pay for a premium procedure, they expect a little more. How do you continue to manage patient expectations with premium lenses during the postoperative period?

Dr. Freeman: You know the old saying: Any symptom that you have postop that wasn't gone over in preop is a problem. The key to managing patients postoperatively is to have good preoperative education. This will preempt any doubt that they may have. Then, in the postop visit, repeat this same messaging so it resonates. If you continually tell patients the same thing—even if it's something unpleasant—they will have more confidence in you after they've experienced it. In fact, they'll think you're extra-smart for predicting it.

Dr. Owen: Also, remind patients that improved vision is yet to come. The

first two postop visits should be about the health of the eye—not about the vision. Tell them this ahead of time. Then, in those first visits, talk about how healthy the eye is.

Anticipate Glare and Halos

Dr. Karpecki: When you are presented with a case of a postoperative patient mentioning glare or halos, how do you manage it?

Dr. Bloomenstein: Glare and halos are perfectly natural in the postop period. Let the patient know that he shouldn't be alarmed by what he sees on the drive home.

Dr. Geffen: Exactly. Tell patients ahead of time that they will have glare and brightness sensitivity. We're removing a cataract that has been absorbing 25% to 30% or more of the light. Naturally, the patient is going to be light-sensitive. This light sensitivity will manifest itself in a variety of ways. Don't let this come as a surprise.

Dr. Bloomenstein: The good news is, nowadays, with lenses like the TECNIS® Multi-focal 1 piece IOL, we see few significant glare and halo difficulties. We've come a long way.

1. Prevent Blindness America and the National Eye Institute, the 2012 Vision Problems in the U.S. report. <http://www.visionproblemsus.org/index.html>. Accessed August 25, 2014.

2. Market Scope. 2014 Comprehensive Report on the Global Cataract Surgical Equipment Market. June 2014.

3. Harmon D, Merritt J (Market Scope, LLC). Demand for Ophthalmic Services and Ophthalmologists—A Resource Assessment. April 2009.

IMPORTANT SAFETY INFORMATION

Rx Only

ATTENTION: Reference the labeling for a complete listing of Important Indications and Safety Information.

CATALYS® Precision Laser System

CONTRAINDICATIONS: Should not be used in patients with corneal ring and/or inlay implants, severe corneal opacities, corneal abnormalities, significant corneal edema or diminished aqueous clarity that obscures OCT imaging of the anterior lens capsule, patients younger than 22 years of age, descemetocoele with impending corneal rupture, and any contraindications to cataract surgery. **ADVERSE EFFECTS:** Complications include mild Petechiae and subconjunctival hemorrhage due to vacuum pressure of the LIQUID OPTICS Interface suction ring. Potential complications and adverse events include those generally associated with the performance of capsulotomy and lens fragmentation, or creation of a partial-thickness or full-thickness cut or incision of the cornea. **CAUTION:** Should be used only by qualified physicians who have extensive knowledge of the use of this device and have been trained and certified by Abbott Medical Optics/OptiMedica.

TECNIS® Multifocal Family of 1-Piece IOLs

WARNINGS: Physicians considering lens implantation should weigh the potential risk/benefit ratio for any conditions described in the Directions for Use that could increase complications or impact patient outcomes. Multifocal IOL implants may be inadvisable in patients where central visual field reduction may not be tolerated, such as macular degeneration, retinal pigment epithelium changes, and glaucoma. The lens should not be placed in the ciliary sulcus. Inform patients about the possibility that a decrease in contrast sensitivity and an increase in visual disturbances may affect their ability to drive a car under certain environmental conditions, such as driving at night or in poor visibility conditions.

PRECAUTIONS: Prior to surgery, inform prospective patients of the possible risks and benefits associated with the use of this device and provide a copy of the patient

information brochure to the patient. The long term effects of intraocular lens implantation have not been determined. Secondary glaucoma has been reported occasionally in patients with controlled glaucoma who received lens implants. Do not reuse, resterilize or autoclave.

ADVERSE EVENTS: The rates of surgical re-interventions, most of which were non-lens related, were statistically higher than the FDA grid rate for both the ZMB00 (+4.00 D) and ZLB00 (+3.25 D) lens models. For the ZMB00, the surgical re-intervention rates were 3.2% for first eyes and 3.3% for second eyes. The re-intervention rate was 3.3% for both the first and second eyes in the ZLB00 group.

TECNIS® Toric 1-Piece IOL

WARNINGS: Physicians considering lens implantation should weigh the potential risk/benefit ratio for any circumstances described in the TECNIS® Toric 1-Piece IOL Directions for Use that could increase complications or impact patient outcomes. The clinical study did not show evidence of effectiveness for the treatment of preoperative corneal astigmatism of less than one diopter. The TECNIS® Toric 1-Piece IOL should not be placed in the ciliary sulcus. Rotation of the TECNIS® Toric 1-Piece IOL away from its intended axis can reduce its astigmatic correction. Misalignment greater than 30° may increase postoperative refractive cylinder. **PRECAUTIONS:** Accurate keratometry and biometry in addition to the use of the TECNIS® Toric Calculator (www.TecnisToric-Calc.com) are recommended to achieve optimal visual outcomes. The safety and effectiveness of the toric intraocular lens have not been substantiated in patients with certain preexisting ocular conditions and intraoperative complications. Refer to the TECNIS® Toric 1-Piece IOL Directions for Use for a complete description of the preexisting conditions and intraoperative complications. All preoperative surgical parameters are important when choosing a toric lens for implantation. Variability in any of the preoperative measurements can influence patient outcomes. All corneal incisions were placed temporally in the clinical study. Do not reuse, resterilize, or autoclave. **ADVERSE EVENTS:** The most frequently reported cumulative adverse event that occurred during the TECNIS® Toric 1-Piece IOL clinical trial was surgical re-intervention which occurred at a rate of 3.4% (lens repositioning procedures and retinal repair procedures).

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