Success with toric and multifocal IOLs

by Francis Mah, MD

The 2014 ASCRS Clinical Survey demonstrated educational gaps regarding toric and multifocal intraocular lenses

The ASCRS Clinical Survey revealed important information regarding members’ use of toric and multifocal intraocular lenses (IOLs).1 This annual survey is conducted to examine the most compelling and controversial issues facing ASCRS members. It included 267 data points from 134 questions on key clinical opinions and practice patterns. It surveyed more than 1,500 unique respondents.

Toric IOLs

After implanting a toric intraocular lens (IOL), 33% of respondents believe 10 degrees of postoperative rotational error or more does not significantly affect visual quality or quality (Figure 1).

When members were asked, “How are you aligning the preoperative axis assessed with your diagnostic tools with your intraoperative axis where you are placing the toric IOL during surgery?” 37% of respondents are not using any instrumentation to guide their alignment marks. Of these, 6% use anatomic landmarks without preoperative marking, and 31% use ink marking at the slit lamp without additional instruments. I found this very surprising. They were correcting astigmatism, however, they were not using any instrumentation to guide the alignment of toric IOLs.

The survey results demonstrated little consensus on how to manage 1.25 D of astigmatism (Figure 2). Nearly 54% chose toric IOLs.

Figure 1. The 2014 ASCRS Clinical Survey asked, “After implanting a toric IOL, how many degrees of postoperative rotational error is acceptable before visual quality and visual acuity are significantly affected?”

<table>
<thead>
<tr>
<th>Degree Range</th>
<th>U.S.</th>
<th>Non-U.S.</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5</td>
<td>45.0%</td>
<td>40.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>5</td>
<td>35.0%</td>
<td>30.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>6 to 9</td>
<td>20.0%</td>
<td>15.0%</td>
<td>15.0%</td>
</tr>
<tr>
<td>10</td>
<td>5.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Great than 10</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

33% of respondents believe >10 degrees of error does not significantly affect visual quality/acuity.

Figure 2. The survey asked, “What is your most common procedure to manage astigmatism in a cataract patient with the following levels of cylinder?”

<table>
<thead>
<tr>
<th>Cylinder Level</th>
<th>0.75 D</th>
<th>1.25 D</th>
<th>2 D</th>
<th>3 D</th>
</tr>
</thead>
<tbody>
<tr>
<td>On axis incision</td>
<td>42.1%</td>
<td>12.0%</td>
<td>0.9%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Manual LRI or AK</td>
<td>13.2%</td>
<td>17.1%</td>
<td>3.5%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Femtosecond laser LRI or AK</td>
<td>7.9%</td>
<td>8.3%</td>
<td>1.6%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Toric IOL</td>
<td>5.9%</td>
<td>53.9%</td>
<td>89.7%</td>
<td>91.6%</td>
</tr>
<tr>
<td>Postop laser vision correction</td>
<td>0.9%</td>
<td>1.6%</td>
<td>2.7%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Glasses or contact lenses</td>
<td>7.1%</td>
<td>5.3%</td>
<td>1.5%</td>
<td>1.8%</td>
</tr>
<tr>
<td>No special correction needed</td>
<td>22.9%</td>
<td>1.9%</td>
<td>0.1%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Little consensus on how to manage a 1.25 D patient
Toric IOLs: Planning for success

Experts share their preoperative strategies to optimize outcomes

To achieve optimal refractive outcomes with toric intraocular lenses (IOLs), clinicians need to carefully lay the groundwork when performing preop assessments and selecting technology.

Diagnostic requirements


She performs tear osmolarity tests during each cataract surgery consult. If osmolarity is greater than 308 mOsml, she begins treatment. “If you base your toric calculations on a hyperosmolar ocular surface setting, you are going to end up with a surprise, and not a pleasant surprise,” she said. Dry eye affects keratometry, topography, and wavefront imaging, she explained.

She performs the InflammaDry test for MMP-9 (Rapid Pathogen Screening, Sarasota, Fla.), lissamine green staining, the Sjö Diagnostic Test (Bausch + Lomb, Bridgewater, N.J.) if appropriate, and ocular allergy testing. She asks patients to stop wearing their contact lenses 2 to 4 weeks before testing because they impact astigmatism measurements.

Based on disease severity, treatment may include preservative-free artificial tears, oral omega-3 supplements, cyclosporine ophthalmic emulsion 0.05%, loteprednol 0.5% gel or ointment, or a microwavable heat mask.

To measure the magnitude and axis of cylinder, Dr. Matossian compares Ks for axis and magnitude with 4 different pieces of equipment: a manual keratometer that is calibrated daily, IOLMaster (Carl Zeiss Meditec, Jena, Germany) or LENSTAR (Haag-Streit, Jena, Germany) or OPD III topographer and wavefront analyzer (Marco, Jacksonville, Fla.), and Cassini (i-Optics, The Hague, the Netherlands) to examine the posterior cornea.

“If there is greater than 10 degrees of difference in your Ks or more than 0.5 D in the magnitude of your Ks, you have to stop,” she said. “You have to figure out what is going on. What is it that's giving you unreliable data?”

Ultimately, for toric IOL success, the surgeon must optimize the ocular surface, compare Ks, review the pattern of the astigmatism for symmetry (bow-tie pattern), assess the posterior cornea, and be sure the patient leaves out his or her contact lenses before testing, Dr. Matossian said.

IOL selection

In selecting an IOL, it is important to consider IOL optics, said Mark H. Blecher, MD, co-director, Cataract and Primary Eye Care, Wills Eye Hospital, Philadelphia, during the ASCRS program.

“You are not going to have good astigmatism correction or good multifocality and reading ability if you don’t start with good optics,” he said.

Dr. Blecher chooses IOLs without glue insertions and that provide full transmission of healthy blue light, correction of spherical aberration to essentially zero, and a high Abbe number and less light dispersion resulting in less chromatic aberration.

Lenses material and manufacturing are also important concerns. Lenses can be injection molded or lathe cut. “Cryolathing takes a little longer to produce lenses, but it gives you a much finer finish,” he said.

In addition, Dr. Blecher looks for ease of insertion, with bag-friendly coplanar delivery, reduced lens thickness, and polished haptic loops.

Stability is particularly important with toric IOLs (Figure 1). “I like a vaulted lens because it puts the optic farther back against the capsular bag,” he said. “It keeps it closer to the nodal point to the eye, and it gives you a little more stable fixation because the haptics and the optic are independently fixated in the bag.”

Proper patient selection is critical for high technology lenses, which continue to evolve, he said. Suitable candidates for toric lenses should desire good uncorrected distance vision but be comfortable with spectacles for near. They also should have more than 1.0 D regular astigmatism on corneal topography, he said. While one can use toric lenses in cases of irregular or nonorthogonal astigmatism, results—while good—can be a bit less predictable, he said.

“Our success with these lenses will be further improved as we are better able to measure preoperative total corneal astigmatism and better anticipate postop refractive cylinder,” Dr. Blecher said.

Dr. Matossian can be contacted at cmatossian@matossianeye.com, and Dr. Blecher can be contacted at mhbmd@comcast.net.
Multifocal IOLs
The survey also revealed multifocal IOL trends among members.

Regarding patients receiving presbyopia-correcting IOLs, 44% of respondents believe 0.75 D or more postoperative residual cylinder error is acceptable after surgery (Figure 3). Approximately half do not use laser vision correction to correct residual cylinder.

When respondents were asked how satisfied their presbyopia-correcting IOL patients were with their outcomes at near, intermediate, and distance 1 year after surgery, patients were significantly less satisfied with their intermediate vision (Figure 4).

Closing the gap
Based on needs identified from this survey, this supplement highlights strategies and recommendations from some of ophthalmology’s leading experts on toric and multifocal IOLs.

Reference

Dr. Mah is director of the cornea service and codirector of the refractive surgery service, Scripps Clinic, La Jolla, Calif. He can be contacted at Mah.Francis@ScrippsHealth.org.

“The regarding patients receiving presbyopia-correcting IOLs, 44% of respondents believe 0.75 D or more postoperative residual cylinder error is acceptable after surgery.”

<table>
<thead>
<tr>
<th>Most likely method to correct significant amount of residual cylinder</th>
<th>U.S.</th>
<th>Non-U.S.</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laser vision correction</td>
<td>52.4%</td>
<td>63.4%</td>
<td>58.0%</td>
</tr>
<tr>
<td>LRI/AK</td>
<td>34.4%</td>
<td>11.0%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Glasses or contact lenses</td>
<td>13.2%</td>
<td>22.9%</td>
<td>18.4%</td>
</tr>
<tr>
<td>Other</td>
<td>0.0%</td>
<td>2.6%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

44% believe ≥0.75 D of residual error is acceptable, and half do not use LVC to manage residual error.

Figure 3. The survey asked, “In patients implanted with a presbyopia-correcting IOL, what is the lowest amount of postoperative residual cylinder error that you consider to be visually significant?” The average was 0.63 D, and 44.0% stated 0.75 D or greater.

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>U.S.</td>
</tr>
<tr>
<td>Near vision</td>
<td>7.2</td>
</tr>
<tr>
<td>Intermediate vision</td>
<td>6.2</td>
</tr>
<tr>
<td>Distance vision</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Intermediate vision has significantly lower levels of satisfaction.

Figure 4. The survey asked, “Overall, how satisfied are your presbyopia-correcting IOL patients with their outcomes at the following distances at 1 year postop? (0=Least satisfied, 10=Most satisfied)”
Intraoperative and postoperative steps to success with toric IOLs

Attention to detail is crucial in reducing spectacle dependence

When patients invest in premium technology, such as toric intraocular lenses (IOLs), they expect premium outcomes, said Jeremy Z. Kieval, MD, director of cornea, cataract, and refractive surgery, Lexington Eye Associates, Lexington, Mass., during a presentation at the 2015 ASCRS•ASOA Symposium & Congress in April.

To meet these expectations, surgeons must optimize each surgical step and be prepared to provide enhancements if necessary.

Intraoperative strategies
Stability of toric IOLs is critical (Figure 1). For each degree of IOL rotation, the patient loses approximately 3.3% of the power of the cylinder, said Francis S. Mah, MD, director of cornea and external disease, and co-director of refractive surgery, Scripps Clinic, La Jolla, Calif., during the ASCRS program.

Surgeons can choose from low- and high-tech marking methods to guide IOL alignment; the key is that surgeons should mark and help alignment from the beginning. With manual marking techniques, precision and accuracy are key. Surgeons should mark preoperative reference marks on the cornea while the patient is sitting up looking off into the distance to avoid excyclorotation, which invariably occurs when patients lie down, Dr. Mah said. When the patient is supine, the axis of toric IOL placement and the incision should be marked using the preoperative reference marks. If possible, to reduce some of the cylinder, he said, it helps to operate on the steep meridian.

In addition, an array of total cataract refractive suites allow clinicians to capture information in a clinical area and transfer it to the intraoperative area, reducing the risk of error and helping to refine technique and improve outcomes. Although these technological advances are available, they are not essential to get started in the toric IOL arena, Dr. Mah said. It is only when the surgeon wants to try to improve the outcomes and fully invest in the technology that the new equipment is useful, he said.

Dr. Mah highlighted 6 steps to minimize postoperative rotation. First, the surgeon ensures that accurate alignment marks are placed on the limbus before surgery and used to finalize the IOL position.

Second, good wound construction and correct capsulotomy size are necessary. Third, Dr. Mah uses a cohesive OVD in the IOL injection cartridge and to inflate the capsular bag. “You want to make sure that the implant lens is completely unfolded,” he said. He rotates the lens to be sure the haptics are fully deployed into the capsular apex and aligns the IOL marks with the preoperative marks.

Subsequently, he removes all OVD from the eye. After OVD removal, he taps down on the center of the implant or applies gentle pressure so that the optic is in contact with the posterior capsule.

Next, the wounds must be adequately hydrated and watertight, and the eye must not be overinflated. “Then you want to make sure that you check the wounds at the end of the surgery,” he said.

Postoperative astigmatism
Because patients do not expect to wear glasses full time after toric IOL implantation, enhancements are a strong consideration for residual astigmatism after surgery, Dr. Kieval said.

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Expanding the scope of presbyopia-correcting IOLs with low add power

by Kerry Assil, MD

Low add multifocal IOL options enable surgeons to deliver personalized visual results

Multifocal options

Although the +4.0 D add is excellent for near work such as reading or knitting, we need to encourage these patients to be a bit tolerant and to experiment with different mechanics to help with intermediate work (Figure 1). The +3.25 D add, which is ideal for activities at longer reading distances, such as with multimedia work, solves this to a great degree and reduces halos. These symptoms further decrease with the +2.75 D add, which is geared for intermediate activities such as using a desktop computer or shopping and makes it very comfortable for people to work at arm’s length or closer.

When you look at U.S. Food and Drug Administration data for +4.0 D, +3.25 D, and +2.75 D add multifocal IOLs, more than 80% of patients reported they could read at near, intermediate, and distance (irrespective of specific near add power) without glasses (Figure 2). These results are all the more impressive when considering that the studies didn’t allow for enhancement.

High patient satisfaction was reported with multifocal +3.25 D and +2.75 D add IOLs, which are referred to as the lower adds. More than 93% of patients said they would opt for the same lens again. These IOLs delivered excellent visual outcomes at near and binocular distance, with a J1 mean uncorrected near visual acuity and 20/20 mean uncorrected distance visual acuity.

With the multifocal +3.25 D add IOL in particular, at least 96% reported that they were comfortable without glasses at intermediate and far distances. Furthermore, 94% said they would choose the same technology again, despite the fact that astigmatism was not corrected and A constants were not yet optimized. Therefore, one can most likely view these as baseline results. Ninety-nine percent of patients had 20/40 or better near vision without glasses.

Enhancement options include IOL rotation, laser vision correction, IOL exchange, or limbal relaxing incisions. “The first and foremost thing that you need to do with these patients is rule out organic or iatrogenic disease,” he said. Surgeons should check for ocular surface disease, subtle basement membrane dystrophies, other irregular astigmatism, surgically induced astigmatism, posterior corneal astigmatism, extremes of axial length, and IOL tilt (Figure 2).

If surgery was performed more than 2 years ago, Dr. Kieval chooses laser vision correction. When it has been less than 2 weeks, however, he monitors the patient. If the capsule is open, he performs laser vision correction.

He also examines whether the IOL is at the intended axis or an unintended axis and recommended the Toric Results Analyzer developed by John Berdahl, MD, and David Hardten, MD (astigmatismfix.com) for guidance.

He rotates the lens if the postrotation spherical equivalent will be less than 0.5 D. If not, surgeons may consider laser vision correction or IOL exchange, he said.

If final cylinder is not less than 0.5 D, surgeons need to find out why, ruling out iatrogenic disease, and consider laser vision correction or IOL exchange.

“If you follow a systematic approach, you can really enhance patients’ satisfaction and your success with toric lenses,” Dr. Kieval said.

Dr. Mah can be contacted at Mah.Francis@scrippshealth.org, and Dr. Kieval can be contacted at jkieval@lexeye.com.
Multifocal IOLs: Targeting residual refractive error

by David R. Hardten, MD

To achieve optimal results, surgeons must plan for patients who require postoperative enhancements

The most common reasons for patient dissatisfaction after implantation of presbyopic intraocular lenses (IOLs) are residual refractive error (sphere and cylinder), glare, and halos.

Although patients may lack effective range of focus, most eventually neuroadapt. Cystoid macular edema and dry eye may occur, which must be treated.

To improve patient satisfaction with visual results, we need to develop a strategy to effectively manage residual refractive error.

Residual refractive error

In a multifocal clinical trial, more than 80% of patients who received the Tecnis multifocal ZM900 (Abbott Medical Optics, Abbott Park, Ill.) did not wear glasses. Among those who require glasses after implantation of presbyopic IOLs, residual astigmatism may be one reason.

In our cataract practices, more than 70% of patients have 0.5 D of preoperative cylinder or more. To achieve patient satisfaction, residual astigmatism must end up less than 0.5 D.

In patients with more than 0.5 D astigmatism, I debulk the astigmatism with astigmatic keratotomy (AK) performed manually or with a femtosecond laser, typically at a 9-mm optical zone. On-axis incisions can be used for small amounts of astigmatism.

If there is residual refractive error after implanting a toric or multifocal IOL, we can correct spherical and astigmatic errors with laser vision correction.

I tend to perform large corrections earlier. For example, if a patient has 3.0 D astigmatism before surgery, most likely this will remain after surgery. Typically wound edema will disappear and the implant will settle into place 2–3 weeks after surgery, so I may correct this large refractive error earlier.

Most often residual refractive errors range from 0.5–1.0 D. In these cases, I wait 3–6 months, determining whether I first need to perform a YAG capsulotomy. I usually wait 1–2 months to rotate a toric IOL if needed due to residual astigmatism.

In 59 eyes in which we implanted various presbyopic IOLs and had residual refractive error, the spherical equivalent was off by approximately 1.0 D, and there was residual astigmatism of nearly 1.25 D (Figures 1 and 2). We used standard LASIK in most cases, which is possible if the epithelium and stroma are normal and patients have not had LASIK previously. PRK typically is used if the patient has epithelial basement membrane dystrophy, previous scars, or a longer cataract wound. At that time we used wavefront fairly infrequently, however, as our experience has grown with diffractive IOLs, we are better

Methods

- Standard LASIK = 44 eyes (75%)
- Standard PRK = 3 eyes (5%)
- Lift flap custom LASIK = 2 eyes (3%)
- Custom PRK = 3 eyes (5%)
- Custom LASIK = 7 eyes (12%)
- Custom = 20% Standard = 80%

Figure 1. Laser vision correction used in 59 cases after presbyopic IOL implantation

Last follow-up results

- 59 eyes with at least 3 mo follow-up (mean 12.2 mos)
- Mean SE last follow-up = –0.18±0.52 D (absolute of 0.98 D pre-LVC)
- Mean astigmatism = 0.41±0.42 D (1.33 D pre-LVC)
- No eyes with loss of more than 1 line of BCVA (most 1 line thought to be dryness)

Figure 2. Last follow-up results after laser vision correction following presbyopic IOL implantation

Crystalens 33 eyes; ReZoom 12 eyes; ReSTOR 13 eyes; Tecnis MF 1 eye
The most common reason for patient dissatisfaction after implantation of presbyopic IOLs is residual refractive error.

able to obtain an accurate wavefront and use wavefront-guided LASIK or PRK.

As a cataract surgeon, you must decide whether you will implant presbyopic or toric IOLs. If you provide this option, you will need to manage astigmatism and residual refractive error with relaxing incisions, laser vision correction, or co-management with a refractive surgeon. We must have a backup plan for the 15 to 20% of patients with residual refractive error.

Conclusion

Laser vision correction improves visual outcomes after implantation of presbyopic IOLs when patients have residual refractive errors. I usually aim for the predicted spherical equivalent that I want, even if I know there will be astigmatism. Mixed astigmatism protocols work well with current excimer lasers. Our patients have high expectations, so we need to be prepared to provide occasional enhancements.

References


Dr. Hardten practices with Minnesota Eye Consultants, Minneapolis. He can be contacted at drhardten@mneye.com.

Among those who received the multifocal +2.75 D add IOL, 98% of patients reported that they could function comfortably without glasses at intermediate and far distances, and 95% had 20/40 or better near vision without glasses. Ninety-seven percent said they would have the same IOL again, though—as before—no enhancements were performed for astigmatism or residual spherical error and A constants were not yet optimized.

Customizing lens selection

Practice demographics, geographic differences, and patient lifestyles influence IOL powers. I have now implanted several hundred of these IOLs; approximately three-quarters have the +2.75 D add; approximately 20% have the +3.25 D add; and approximately 5% have the +4.0 D add.

After I have ruled out ocular pathology and determined that patients are good candidates for the technology, I ask if they wish to see well without glasses, and most respond that they do. I ask them a few visual demand lifestyle-related questions (e.g., computer use, night driving, preferred reading distance), which guide my IOL choice. I review the benefits expectations and I share the anticipated side effects and safety information.

I also emphasize bilateral procedures. In addition, I stress what to expect afterward, which is very important. Even with the +2.75 D add, I explain that they should expect halos and glare, even though I find that with that lens, the amount of halos and glare is only slightly higher than with a monofocal lens. To achieve success, it is important to under promise so that you can over deliver.

Dr. Assil is medical director and chief executive officer of the Assil Eye Institute, Beverly Hills and Santa Monica, Calif. He can be contacted at info@assileye.com.

Figure 2. Patients’ ability to function comfortably without glasses 6 months after bilateral implantation of multifocal IOLs

<table>
<thead>
<tr>
<th>Percent</th>
<th>Near</th>
<th>Intermediate</th>
<th>Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>81</td>
<td>97.9</td>
<td>97.9</td>
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<tr>
<td>90</td>
<td>85.9</td>
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>80% of patients reported an ability to function comfortably without glasses at all distances
Surgeons who present multifocal IOLs need to value the benefits of this technology

When presenting multifocal intraocular lenses (IOLs) to patients, it is important to understand how various options can be personalized to meet their individual needs.

Cataract surgery candidates
When cataract patients arrive in our office, staff are instructed to determine their refractive error and whether they have astigmatism.

If patients have less than 2 D of astigmatism, I explain that they are candidates for multifocal IOLs, which decrease dependence on glasses (Figure 1). We never tell them that they will be spectacle-free, although more than 90% of our patients with multifocal IOLs do not need glasses.

Because we will always have patients who insist that we explained they would never need glasses and their vision would be 20/20, we must document everything. We require patients to sign forms indicating that they correctly understand what they’ve been told.

If patients have more than 2 D of astigmatism, I explain that they are candidates for monofocal glasses or a monofocal toric IOL. We offer a broad range of toric IOLs, as well as the new Trulign Toric (Bausch + Lomb, Bridgewater, N.J.).

I explain to patients that no one must have cataract surgery. If their vision is 20/100, I tell them that this surgery is optional, but it will help them see better.

Discussing IOL options
If patients elect to have cataract surgery, we discuss their lifestyle choices (Figure 2). Do they want to be dependent on glasses with a standard monofocal IOL? Or do they want to be less dependent on glasses and opt for a multifocal, presbyopia-correcting IOL?

We explain that these IOLs will allow them to enjoy their near and distance vision, and they should be able to perform their hobbies without spectacles, however, we do not over promise. We caution them that they may need to occasionally wear glasses and may experience mild dysphotopsia. We explain that halos are normal with all IOLs and should dissipate over time.

I’m not afraid to tell them that I truly believe in this technology, and I focus on the positive. We strive for perfection. We tell patients, “This is not like your God-given lens, but it certainly is the next best thing.”

If a patient drives regularly at night, I steer them away from these IOLs. It’s not worth the potential risk of disability.

I share that the most significant issue is cost, which they will discuss with our premium IOL counselor. We explain financing options. For some reason, when patients know they can make payments on these implants, they tend to choose them.

Conclusion
I am comfortable speaking with my patients about multifocal IOLs, but some physicians are reluctant to broach the subject. You must believe in the technology in order to present the premium channel in your clinic. I look my patients in the eyes and enthusiastically offer them the technology that will improve their lifestyle.

I have implanted these lenses in executives, medical directors, surgeons, and even a patient who drives a fire truck.

I always ask myself, “Would I place a multifocal lens in my family, friends, colleagues, and even my own eye?” The answer to all of those is, “Yes, I would.”

Dr. Logan is the founder and medical director of Atlantis Eyecare in Huntington Beach, Calif. He can be contacted at dklogan@atlantiseyecare.com.