Modern Day Cataract Care

London 2012
Monday April 30
3:30-4:30 PM

Basic Principles of Cataract Co-Management
- History of Comanagement in the U.S.
- Mechanism developed to pay OD’s for post-op care rendered
- Make sure patient knows of any co-management arrangement and agrees to it willingly

History
- Procedure, Eye, Date, Surgeon
  - S/P Pterygium resection OD x 1 day (Status-post)
  - S/P Trabeculectomy with MMC. POD # 1

Pre/Post-operative medications/instructions
- Moving target
- No clinical studies to support prophylactic antibiotics but many use them anyway
- NSAIDs to prevent CME
- Steroids for inflammation

s/p IOL OS 7/15/10 Dr. Woodard
s/p IOL OD 7/26/10 Dr. Woodard

History
- Subjective complaints
  - Foreign body sensation
  - Pain, discomfort, sleep
  - Nausea, vomiting
  - Visual status/improvement
  - Photopsias, other visual sensations
Component 1: History

- **Eye**: functional history such as “problems with glare/TV/driving at night”
  - Activities of Daily Living: MUST BE DOCUMENTED!

- **Social History**: chronic depression, bipolar, anxiety disorders

- **Observation during exam**: ambivalence, excessive questioning, unrealistic expectations, wanting guarantees

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Past Eye and Medical History Critical

- **Medications**: Flomax?
- **Contact Lens Wearer?**
- **Prednisone (PSC)**
- **Trauma**
- **Family history of cataracts at a young age**
- **Diabetes/hypertension**
  - How long have you had it
  - What do you take for it
  - Is it under control/when last checked
  - Doctor’s name

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Component 2: Vision and Refraction

- **Visual Acuity (D & N)**
- **Pinhole should be part of vision**
  - Monocular diplopia or glare alleviated?
- **Glare testing or BAT (medium setting), or “Ambient Light” (room lights on)**
  for any patient who is 20/40 or better

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Component 3: Ocular Health

- **Slit Lamp**
- **Dilated Fundus Exam**

When in doubt about the retina, get an OCT......especially with premium lenses!

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Time to Write Down Your Impression and Plan

- **Impression**:
  - Cataracts OD > OS with difficulty reading OU
  - 2+ NS consistent with reduced VA
  - Would like to rely less on glasses

- **Plan**:
  - Schedule bilateral Restor IOL’s OD then OS

- Premium IOL discussed, patient not interested/Schedule conventional monofocal IOL OD then OS
Or………

• **Impression:**
  – “Cataracts OU, night driving problems
  – 3+ NS consistent with reduced VA
  – 2 diopters of cylinder

• **Plan:**
  – IOL’s OD then OS
  – Patient denies Toric

Communication Key!

• Communicate pertinent findings directly to surgeon…don’t leave it to chance!
  – Meds (Flomax) and Conditions (Pseudoexfoliation Syndrome, Glaucoma) Ocular Surface Disease

Let Surgeon Know About Lasik Patients!

• Central K from Topo x 3.1 - 6.1
• Modified Maloney Formula
• Gives you K’s that will go into IOLmaster
• Still need to warn patient they have a chance of needing an IOL exchange!

Surgical Techniques

• US and UK/Europe

Laser Refractive Cataract Surgery with the LenSx® Laser
Femtosecond Lasers in Eyecare

- Cornea
  - Flaps for LASIK
  - Transplant Procedures
  - Intrastromal and Lenticule Refractive Procedures
- Scleral
  - Glaucoma Treatments
  - Presbyopia Procedures
- Crystaline Lens
  - Presbyopia Reversal/Delay
  - Cataract Surgery
- Vitreous/Retina
  - Vitreous cutting
  - Retinal imaging/treatment

A New Category in Ophthalmic Surgery

One precise, image-guided femtosecond laser procedure to:
- Effectively fragment the nucleus
- Create a perfectly centered and sized capsulotomy
- Perform complex multi-planar corneal incisions, and
- Accurate incisions to address pre-existing astigmatism

Goals of Laser Refractive Cataract Surgery

- Improve Every Procedure, Technology and Surgeon
  - Presbyopia, Astigmatism & Monofocal
  - Refractive Precision and Integration

Laser Corneal Incisions

Computer-controlled depth, shape and location
- Precise, OCT corneal thickness measurement
- Flexible femtosecond laser incision architecture
- Automated reproducibility allows surgeon to address astigmatism
- Efficacy of femtosecond lasers established in over 3 million corneal incision procedures for LASIK flaps and keratoplasty

BUT.........................

- OR time
- Phako time
- I/A time
- For the top-notch surgeons, is it really going to make a difference?

Private Pay Refractive Cataract Surgery

- Draws from largest surgical market
  - 18M annual WW procedures
  - Grows to 22M WW by 2015
Conclusion

• A new Category is emerging in private pay ophthalmic surgery
• LenSx technology will drive innovation for true

Laser Refractive Cataract Surgery

• Unique precision for capsulotomy and corneal incisions
• Smaller incisions and laser optimized wound architecture
• Improved IOL performance via Effective Lens Positioning
• Correction of pre-existing astigmatism at time of surgery
• A more predictable, safe and reproducible procedure
• Technology that will enable surgeons to deliver better vision

As far as the IOL is concerned...

• The “old days” of sending the patient on to your surgeon and not thinking about the refractive result are over
• You know more about their refractive history than anyone else, so be involved and stay involved

The Choices in High Technology or “Premium” Lenses

• Multifocal lenses
• Accommodating lenses
• Toric lenses
• Multifocal/Toric combination: Europe only!

Who Should You Discuss Premium Lenses with?

• Everyone!
• Tell the non candidates why they are not
• Document in chart

Using the Right Terminology

• Premium lens
• Lifestyle lens
• High Technology Lens
• Multifocal lens

Good Candidates?

• Cataract patient presents with one pseudophakic eye (monofocal lens) and a cataract in the other eye, or a cataract in one eye only
• Patient presents with s/p lasik ou, now has cataracts ou
• Patient has >2 diopters of cylinder
Who should you “watch out” for?

- Patients that are hypercritical with unrealistic expectations
- Patients with over 1 D of cylinder
- Patients who drive at night for a living or with long term glare complaints
- Patients who want guarantees, and think that the price includes glasses and care for life

Save Yourself Some Time

- I mention the cost early on to save a lot of unnecessary discussion
- Document in chart that you offered it and patient declined

Post Op Visits

- CDE on Alcon Infiniti
- "Cumulative Dispersed Energy" = average U/S power × U/S time
- Should be under 5 for most skilled surgeons
- If ever, look for corneal folds/edema
- Ask your surgeon to inform you of abnormal CDE’s

Post-Op Visits: 1 Day, 1 Week

- Check VA and pinhole
- Refract
- IOP
- Slit Lamp: should be trace cell
- Fundus check 1 week or 1 month

Post-Op Visits: 1 Month

- Check VA and pinhole
- If <20/40, refract
- IOP
- Slit Lamp: should be no cell or flare
- Fundus check if didn’t do it at one week
- Final Rx

Post-Op Visits: What’s Different with Premium IOL’s?

- Restor: check reading vision and find the “sweet spot”
- Until second eye is done, vision may not be optimal
- Toric: do a refraction if VA not 20/20 or close
The Case of the Unexplained VA

*69 y/o F, cat sx (ReStor OU) 5 mo ago
*20/20 OD, 20/50 OS (distance UCVA)
*20/25 OS w/+1.00 sph
*J1 OD, J5 OS (near UCVA)
*S/P YAG cap OS 1 mo ago
*Ref for 2nd opinion, poss. LASIK

Low Grade CME

- Subclinical (not visible)
- Hyperopic Shift
- Reasonably good BCVA
- Poor “quality” vision
- OCT/FA needed

CME Treatment

- Topical NSAIDS: Xibrom, Nevanac, Accuvail (recent recall) , generic Diclofenac (Voltaren)
- Topical steroids
- Retrobulbar steroids
- PO NSAIDS

Results after 6 Weeks

- 20/20-1 UCVA distance
- J1 near
- +0.25 sph
- Patient happy!!!!

Post-Op Considerations

- These patients are very sensitive to visual changes, so pay attention to the retina and attend to the ocular surface
PCO

- Our experience: These patients are more sensitive to it.
- Thus...YAG laser capsulotomy earlier than monofocal lenses although best to wait 3 months for insurance purposes

The following can severely affect the outcome of cataract surgery:

- Pterygium
- Salzmann’s Nodular Degeneration

Conclusion