

Pearls for Success With the Crystalens AT-50AO

Don't forget to spend more time with your "20/happy" patients.

BY ROBERT J. WEINSTOCK, MD

Since the FDA's 2003 approval of the Crystalens AT-45 (Bausch + Lomb, Rochester, NY), I have been using the IOL to help me consistently deliver great results to my cataract patients. As improvements have been made to the lens platform, I have found that the outcomes have become more consistent and reliable. With the recent release of the Crystalens AT-50AO (Bausch + Lomb), I am now also able to provide my patients with an improved depth of field, accommodation, and high-quality vision with the added benefits of aspheric optics.

Ten pearls have helped me deliver great outcomes with the Crystalens AT-50AO.

No. 1. PATIENTS' EDUCATION

I feel it is extremely important that patients be educated before they see me in the office. One option is to mail educational materials about the Crystalens to new patients prior to their appointment. In my practice, we have a variety of in-office literature and printed materials that patients can peruse before their examination or while their pupils are dilating. We show videos in the waiting room that describe cataract surgery, the available IOLs, and astigmatic correction. The practice's Web site is another avenue for educating patients about IOLs.

No. 2. DOCTOR-PATIENT COMMUNICATION

Unfortunately, there are mixed messages in the marketplace regarding premium IOLs and spectacle independence. It is extremely important to discuss the risk and benefits of cataract surgery and IOLs with each patient. When I recommend the Crystalens, I let the

patient know that he or she may need reading glasses for heavy reading. This ensures that I properly set the patient's expectations. If the patient says he or she wants to avoid wearing reading glasses at all costs, then I respond that bilateral implantation of the Crystalens targeting distance is not going to accomplish this goal. I may suggest monovision with a Crystalens in the dominant eye and a multifocal IOL in the nondominant eye. If the patient has long-standing myopia and routinely takes his or her glasses off to read, then I make sure he or she understands that this will change after the surgery. I also inform patients that refractive adjustments may be needed postoperatively so that there are no surprises. The better patients' understanding is before surgery, the more likely they are to accept their postoperative results.

No. 3. PATIENTS' COMMUNICATION WITH SURGERY COUNSELORS

After a patient has met with me and received a recommendation on IOLs, he or she usually sees a surgery counselor. This staff member should be knowledgeable about the refractive nature of cataract surgery and the refractive options available to the patient. The counselor should follow a script to avoid confusion and to ensure continuity with my discussion. If questions arise that the surgery counselor cannot answer, he or she asks me for clarification. This process needs to be efficient and seamless so that the messaging is consistent throughout the patient's visit. I entrust my practice's counselors to "profile" the patients and to alert me if they encounter a difficult personality.

No. 4. BIOMETRY

I strongly recommend using the IOLMaster (Carl Zeiss Meditec, Inc., Dublin, CA) or immersion biometry to determine the needed IOL power. A cohesive team in the biometry department will help make sure that the readings are consistent. Many times, previous LASIK or corneal surgery will complicate IOL power calculations. Prior surgery further necessitates an excellent preoperative evaluation with biometry, Orbscan topography (Bausch + Lomb), wavefront scans, and multiple corneal and axial length measurements. Effective communication and documentation from the biometry team help me know exactly what the patient's intended target is for each eye.

No. 5. SURGICAL CONSISTENCY

The more consistent the technique, the more reliable the outcomes. I believe that incisions should be placed in exactly the same location for each case regardless of where the astigmatism lies. The capsulorhexis should be uniform and consistent in size for every case—a more important issue than the actual size. I place the Crystalens inside the capsular bag at exactly the same orientation in all cases so that I may develop a consistent nomogram and track outcomes postoperatively. If the Crystalens does not sit well inside the bag, I can rotate it to ensure that it is stable inside the capsular bag with a posterior vault. The incision must be sealed; using a suture is acceptable, as long as it does not induce significant astigmatism. It is also important to remove viscoelastic from behind the IOL and perform a complete cortical cleanup of the underside of the anterior capsule as well as the posterior capsule.

No. 6. ADDRESSING ASTIGMATISM

Eyes with more than 2.00 D of cylinder are probably better suited to a toric IOL than the Crystalens. Corneal astigmatism greater than 0.50 D should be identified preoperatively with topography and/or keratometry and addressed intraoperatively with limbal relaxing incisions. Postoperative limbal relaxing incisions can also be performed at the slit lamp to further reduce astigmatism and refine the refractive result.

NO. 7. CHECKING THE FIRST EYE'S RESULT

I check the refractive outcome of the patient's first eye before operating on the second eye. There may be unanticipated results or shifts in vision, particularly in postrefractive surgery patients. By examining patients, I can make adjustments to the IOL power for their second eye if need be. For example, a patient has a mildly

myopic outcome in his first eye and is reading well, but he and I are dissatisfied with his distance vision. I can increase my distance target for his second eye in anticipation of a mildly myopic outcome. Another patient might have excellent distance vision, but her reading vision is not as sharp as she would like. In this case, I might target a small amount of myopia in the second eye to help improve near vision.

No. 8. CLOSE FOLLOW-UP

Without observing patients closely, I cannot determine whether my refractive outcomes are on target. Close follow-up allows me to identify postoperative imperfections such as posterior capsular opacification or myopic or hyperopic outcomes and address them. It also helps me to make adjustments to my nomogram. With outcomes software programs such as SurgiVision (Irvine, CA), I can objectively compare my results with national averages and make refinements to the A-constant.

No. 9. POSTOPERATIVE CARE

It is important to achieve the desired refractive outcome safely as well as quickly. I usually wait 3 months before performing an Nd:YAG capsulotomy, additional limbal relaxing incisions, or excimer laser treatments. I find it best to wait for refractive stability and complete healing of the incision. If the patient is dissatisfied with his or her distance vision, I will conduct a monovision trial with a contact lens. I will then perform PRK or LASIK on one eye, and these patients generally wind up happy and spectacle free with mini-monovision.

NO. 10. MORE TIME WITH HAPPY PATIENTS

Often, we spend most of our time in clinic dealing with the one or two unhappy patients and breeze quickly through the "20/happy" patients. It can be a real practice builder to stop and bond with these potential ambassadors. Let them know they can thank you by sharing their story with their friends. Have such patients offer a testimonial on your Web site, or ask them to talk to other patients in the office who are thinking about cataract surgery. These patients are the best form of advertising you can find. ■

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