If the ultimate goal of implanting a multifocal IOL (MFIOL) is to achieve spectacle independence after cataract surgery, then choosing a lens with a trifocal diffractive optic may be more advantageous than one with a bifocal diffractive design. Such is a conclusion based on data from studies investigating visual outcomes and optical performance with trifocal diffractive MFIOLs, said Rudy M.M.A. Nuijts, MD, PhD, professor of ophthalmology, Maastricht University Medical Center, Maastricht, The Netherlands.

Dr. Nuijts provided an overview of existing literature on trifocal MFIOLs (not commercially available in the United States), including a randomized, controlled trial his group conducted comparing trifocal and bifocal diffractive MFIOLs. “Overall, the evidence suggests a trifocal MFIOL provides slightly better intermediate vision than a bifocal MFIOL while maintaining good near and distance vision,” Dr. Nuijts said. “Nevertheless, the incidence of optical phenomena, which is also considered a limitation of bifocal diffractive MFIOLs, appears similar with the bifocal and trifocal designs.”

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Multifocal IOL EVOLUTION

Trifocal designs appear to target better intermediate vision than bifocal diffractive MFIOLs in studies

By Cheryl Guttman Krader;
Reviewed by Rudy M.M.A. Nuijts, MD, PhD, and Soraya M.R. Jonker, MD

MAASTRICHT, THE NETHERLANDS :: IF THE ULTIMATE GOAL of implanting a multifocal IOL (MFIOL) is to achieve spectacle independence after cataract surgery, then choosing a lens with a trifocal diffractive optic may be more advantageous than one with a bifocal diffractive design.

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(Continues on page 14: Trifocal)
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Average improvement in BCVA at week 26 was nearly 3 lines

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ERePORT


ACRYLONIQUE I.Q. TAPER ASPHAGIASM IOL

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INDICATIONS: The AcrySof® I.Q. Toric posterior chamber intraocular lenses are intended for primary implantation in the capsular bag of the eye for visual correction of aphakia and pre-existing corneal astigmatism secondary to removal of a cataractous lens in adult patients with or without presbyopia, who desire improved uncorrected distance vision, reduction of residual refractive cylinder and increased spectacle independence for distance vision.

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Optical theory suggests that high astigmatic patients (i.e. > 2.5 D) may experience spatial distortions. Possible toric IOL related factors may include residual cylindrical error or axis misalignments. Prior to surgery, physicians should provide prospective patients with a copy of the Patient Information Brochure available from Alcon for this product informing them of possible risks and benefits associated with the AcrySof® I.Q. Toric Cylinder Power IOLs.

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Equal pay for equal work

By Peter J. McDonnell, MD
director of the Willmer Eye Institute,
Johns Hopkins University School of Medicine, Baltimore, and chief medical editor of Ophthalmology Times.

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“What is negotiation but the accumulation of small lies leading to advantage?”

—Felix Dennis

“ELLEN PAO IS SWIFTLY emerging as the new face of feminism in the United States,” declared a recent article in the business/finance literature.

That name may ring a bell to some readers because of Pao’s recent lawsuit against her former employer. She sued for $160 million ($16 million in lost wages and $144 million in punitive damages) after not being promoted within one of Silicon Valley’s biggest venture capital firms, claiming that the decision was the result of gender discrimination.

The lawsuit received a lot of attention in the media because of the facts that sounded less like something from the business school literature and more like something in “Playboy” (or so I imagine).

Numerous salacious details came out in the testimony, including romantic trysts and employees wearing bathrobes showing up at their colleagues’ hotel room doors. These are the details inquiring minds want to know. The jury ultimately weighed in by deciding that the plaintiff had not been a victim of gender discrimination.

“Come up with an offer that we think is fair . . . we aren’t going to reward people who are better negotiators with more compensation,” Pao explained.

In an article about this change, “Pao defended her move based on studies that have shown that when women negotiate, they don’t fare as well as male counterparts.”

According to a study by Linda Babcock, a professor at Carnegie Mellon University, “when women negotiate, both men and women are less likely to want to work with them. Men, on the other hand, are much more respected for their negotiation skills. For women, it’s generally a lose-lose situation.”

WHAT’S FAIR IS FAIR

I agree that this approach has a lot of merit. Why shouldn’t people earn a fair degree of compensation, in a transparent manner, for their work, and why should a company that has ten people doing the same job be paying them ten different amounts?

In an ophthalmology practice or academic department, should hiring a new associate resemble a visit to a car dealership, in which an applicant willing to delay and engage in protracted discussions be rewarded financially relative to his or her equally well-trained and productive colleague?

How about a system that clearly states how base and bonus compensation are determined and let employees—through their actions and measurable productivity—determine their compensation, irrespective of the number of X chromosomes they may possess? ■

Reference


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Triamcinolone acetonide for uveitis shows promise

Average improvement in best-corrected visual acuity at week 26 was nearly 3 lines

By Nancy Groves; Reviewed by Debra A. Goldstein, MD

CHICAGO ::

Patients with noninfectious uveitis who were treated with a single suprachoroidal injection of triamcinolone acetonide in a 6-month phase I/II clinical trial exhibited improvements in best-corrected visual acuity (BCVA), said investigator Debra A. Goldstein, MD.

The injection was generally safe and well tolerated, said Dr. Goldstein, professor of ophthalmology and director, Uveitis Service, Northwestern University Feinberg School of Medicine, Chicago. Dr. Goldstein helped design the trial, in which eight patients at three U.S. centers received an injection of a commercially available formulation of triamcinolone acetonide using a proprietary microinjector (Clearside Biomedical Inc.)

No serious adverse events related to the drug or the injection were observed over the course of the trial. No patients developed or had progression of cataract and none had an elevation in IOP. However, all eight patients experienced an adverse event of some sort, most commonly pain or redness at the injection site.

Although the trial was not designed to evaluate efficacy, the limited data showed good results. Four patients showed improvements of ≥2 lines of BCVA as early as week 4.

“This persisted for all 26 weeks of the study, suggesting that the injection does last a long time,” Dr. Goldstein said. The average was close to 3 lines of improvement at week 26.

Seven of the eight patients had macular edema and four also had vitreous haze. One of the study endpoints was a 20% reduction in macular edema, which is generally considered a valid endpoint.

By week 1, 40% of patients had met this target; 71% reached the endpoint by week 4, and 67% of eyes retained the reduction in macular edema by the end of the study. Some patients also had complete resolution of macular edema, which persisted for the 6 months of the study.

**Novel Aspects of Study**

The novel aspects of this trial were the injection site and the injector system, Dr. Goldstein said.

Animal data on suprachoroidal injections suggest a better effect can be achieved with a lower dose of triamcinolone than is typically used for intravitreal injection, which potentially could reduce the risk of side effects. Also, because the drug does not enter the vitreous cavity, patients are unlikely to experience the floaters commonly seen after intravitreal steroid injection. The suprachoroidal injection may last longer than intravitreal injections, which typically last only 3 to 4 months.

Animal data also suggest that the drug can partition well by suprachoroidal injection, with almost no drug seen in the anterior segment, thereby reducing the risk of cataract and glaucoma, and concentrating primarily in the outer retina and choroid, the areas needed to improve visual acuity.

With the microinjector system, the injection is performed 4 mm posterior to the limbus with a 30-gauge needle, which is customary for intracocular injections. However, the needles are much shorter than usual, Dr. Goldstein said.

Investigators had a choice of needles of 850, 900, 950, or 1,100 μm; 30-g needle is performed 4 mm posterior to limbus. The appropriate needle was selected by measuring scleral thickness at the injection site with ultrasound. The drug was injected between the sclera and the choroid.

Enrollment has begun for a phase II study after suprachoroidal injection of triamcinolone, illustrating drug in the suprachoroidal space and in the choroid.

**Take-home**

- Results of a 6-month phase I/II clinical trial of suprachoroidal injection of triamcinolone for noninfectious uveitis showed the treatment was safe and well tolerated.

**Procedure**

- 4 mm posterior to limbus
- Ultrasound assessment of scleral thickness
- 850, 900, 950, or 1,100 μm; 30-g needle
- 0.80 mm

**Figure 1** Transverse B-scan ultrasound illustrating measurement of scleral thickness prior to injection. (Images courtesy of Debra A. Goldstein, MD)

**Figure 2** Ultrasound images taken immediately after suprachoroidal injection of triamcinolone, illustrating drug in the suprachoroidal space and in the choroid.

**Figure 3** Patient with chronic uveitis and cystoid macular edema (CME). The CME resolved 4 weeks after injection. Top photo illustrates the CME before injection; bottom photo demonstrates persistence of the steroid effect 6 months after the injection.

**Debra A. Goldstein, MD**

dgolds@yahoo.com

Dr. Goldstein is a consultant for Clearside Biomedical Inc.
References:

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Adherence to drug regimens may increase with generics

Switching therapies may help some patients with high co-payments, racial minority groups

By Lynda Charters; Reviewed by Joshua D. Stein, MD, MS

ANN ARBOR, MI ::

GLAUCOMA MEDICATION adherence continues to be a major challenge for some patients, with several studies having reported compliance rates of only 50% or lower, said Joshua D. Stein, MD, MS.

Though patients may struggle with their regimens for various reasons, medication cost remains a major factor, said Dr. Stein, associate professor, Department of Ophthalmology and Visual Sciences, University of Michigan, and director, Center for Eye Policy and Innovation, W.K. Kellogg Eye Center, Ann Arbor, MI.

Quantifying the impact of cost on adherence can be difficult, however, he explained.

For instance, patients may be too embarrassed to admit to financial burdens imposed by drug regimens, either when filling out research surveys or participating in focus groups.

Prostaglandin analogues—among the most frequently prescribed and most effective drugs to treat open-angle glaucoma—require only once-daily dosing and have minimal side effects. However, they are also among the most expensive of the glaucoma drugs, said Dr. Stein, adding that some patients pay more than $100 out of pocket each month.

LATANOPROST AS GENERIC

With the commercial availability of the first generic prostaglandin analogue, i.e., latanoprost, in 2011 in the United States, some patients saw a considerable and potential reduction in financial burden.

In light of this, Dr. Stein and colleagues conducted a study to determine if the availability of latanoprost for open-angle glaucoma had an effect on patient adherence. Specifically, was there an impact to patients’ drug regimens after they switched from a brand-name drug to a generic counterpart, compared with other patients with glaucoma who continued taking a brand-name prostaglandin analogue?

Investigators evaluated data from a large, managed-care database of patients aged 40 or more years who received a diagnosis of open-angle glaucoma and were followed in the plan from September 2009 to December 2012. All patients in the medical plan were also enrolled in the pharmacy plan.

Patients had at least one record of a prescription for a brand-name prostaglandin analogue before 2009. The study thus avoided patients who were newly treated during the first 18 months of the study period.

All patients were taking a brand-name prostaglandin analogue before the generic version of latanoprost became available. Patients were excluded if they had undergone a surgery or laser treatment for glaucoma.

Investigators defined improved adherence to medication as an increase of 25% or more in the proportion of days covered by a drug and worsening adherence as a decrease of 25% or more, he explained.

A total of 8,427 patients met the study inclusion criteria, with more than 2,000 patients taking each of the three brand-name medications—branded latanoprost (Xalatan, Pfizer Pharmaceuticals); bimatoprost (Lumigan, Allergan); and travoprost (Travatan Z, Alcon Pharmaceuticals)—before the introduction of generic latanoprost to the market.

There was little change in the rates of medication adherence among patients who continued taking a brand-name product after the generic became available, Dr. Stein noted.

TAKE-HOME

- Adherence to glaucoma medication is a major challenge for some patients due to a variety of factors, including financial burden. Making a switch in treatment from branded to generic drugs may make a difference for patients in certain cases.

SUBSET, OTHER FACTORS

“However, for a subset of patients who were switched to generic latanoprost, adherence to their initially prescribed, brand-name drug was lower than average, yet subsequently increased substantially after the switch to the generic product,” Dr. Stein said.

Of special interest were factors identified by regression analysis that were associated with improved adherence. Results showed that patients remaining on a brand-name drug had a 28% reduced odd of improved adherence and a 39% higher odd of worsening of adherence.

Factors associated with improved adherence include use of generic latanoprost in the post-introductory period, higher insurance co-payments in the post-generic period, lower insurance co-payments in the post-generic period, and black race.

Variables associated with reduced rates of adherence include use of brand-name drugs throughout the study period, higher monthly insurance co-payments in the post-introduction period, and a lack of visits to eye-care providers.

Dr. Stein and co-investigators suggest ophthalmologists consider switching treatments for patients who are not adhering to their glaucoma-medication regimens to a generic product, if possible.

“This may be particularly helpful for patients with high medication co-payments and for patients from racial minority groups,” he said. “Such persons may discontinue use of their medical glaucoma treatment altogether if they simply cannot afford the medications they are prescribed.”

Dr. Stein did not indicate any proprietary interest in the subject matter.
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NO CAPSULE SUPPORT: ANTERIOR VERSUS POSTERIOR CHAMBER IOL

Surgeons should be aware of variety of techniques for aphakic eyes that lack capsular support

By Vanessa Caceres; Reviewed by Richard S. Hoffman, MD

Avoid AC IOLs when . . .
Richard S. Hoffman, MD, recommended avoiding anterior chamber (AC) IOLs if a patient has glaucoma, a shallow anterior chamber, insufficient iris tissue, or corneal endothelial dystrophy.

Contraindications to Iris Fixation
- Large iris defects
- Iridoschisis
- Iris atrophy
- Aniridia
- Active youth
  - Suture tearing
  - Suture slippage

TECHNOLOGICAL ADVANCES IN IOLs

Continues on page 12:
Capsule support

When considering IOL implantation options when there is a lack of capsular support, cataract surgeons should use the approach with which they are most comfortable. They should also continue to learn about new available techniques.

Available options for managing cases where there is a lack of capsule support include an anterior chamber (AC) IOL, a scleral-fixated posterior chamber (PC) IOL, an iris-fixated PC IOL, and intrascleral haptic capture, he noted.

“TO date, no studies have shown that any one technique is superior to the others,” said Dr. Hoffman, clinical associate professor of ophthalmology, Casey Eye Institute, Oregon Health and Science University, Eugene.

Dr. Hoffman cited several studies that supported open-loop AC IOLs and that found this approach posed no greater threat than PC IOLs in the realm of visual outcomes in secondary IOL implantation.1-3

However, some complications with AC IOLs include pain, bullous keratopathy, angle-closure glaucoma, and chronic uveitis. A properly sized, modern Kelman-style open loop AC IOL may help avoid some of these complications and is easily inserted, has a polished finish, and flexible haptics, Dr. Hoffman said.

Dr. Hoffman recommended avoiding AC IOLs if a patient has glaucoma, a shallow anterior chamber, insufficient iris tissue, or corneal endothelial dystrophy.

If implanting a scleral-fixated IOL, Dr. Hoffman advised operating temporally to reduce astigmatism and using 9-0 Prolene or CV8 Gore-Tex. He did not recommend the use of 10-0 Prolene.

He said he also tries to avoid passing sutures at 9 o’clock and 3 o’clock. Two-point fixation is simpler, but four-point fixation allows for greater stability and less lens tilt. Four-point fixation can be associated with an increase in bleeding due to twice as many suture passes through the sclera, Dr. Hoffman said.

If using transscleral fixation, users should bury, cover, or rotate scleral knots to prevent conjunctival erosion and the risk for subsequent endophthalmitis, Dr. Hoffman said.

Continues on page 12:
Indication
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- Use of steroids after cataract surgery may delay healing and increase the incidence of bleb formation and occurrence of perforations in those with diseases causing corneal and scleral thinning. The initial prescription and renewal of the medication order should be made by a physician only after examination of the patient with the aid of magnification, and where appropriate, fluorescein staining.
- Prolonged use of corticosteroids may suppress the host response and thus increase the hazard of secondary ocular infection. In acute purulent conditions, steroids may mask infection or enhance existing infection.
- Use of a corticosteroid medication in the treatment of patients with a history of herpes simplex requires great caution. Use of ocular steroids may prolong the course and exacerbate the severity of many viral infections of the eye (including herpes simplex).
- Fungal infections of the cornea are particularly prone to develop coincidentally with long-term local steroid application. Fungus invasion must be considered in any persistent corneal ulceration where a steroid has been used or is in use.
- Patients should not wear contact lenses when using LOTEMAX® GEL.
- The most common ocular adverse drug reactions reported were anterior chamber inflammation (5%), eye pain (2%) and foreign body sensation (2%).

Please see brief summary of Prescribing Information on adjacent page.
Some ways to avoid suture erosion with scleral-fixated IOLs include burying the knot in the scleral groove, rotating the knots, leaving the suture ends long, attempting multiple zig-zag scleral passes, covering the knot under the scleral flap, performing intrascleral haptic capture, or using a scleral collar.

Another approach that surgeons could use is to suture iris fixation of PC IOLs. Some contraindications for this approach include large iris defects, iridocochisis, iris atrophy, aniridia, and a younger person who is particularly active, as too much activity could lead to suture tearing or suture slippage, Dr. Hoffman said.

Intrascleral haptic capture is another possible approach for lack of capsule support. Some complications intraoperatively include hyphema, haptic breakage, and a deformed haptic. Early complications include corneal edema, epithelial defects, and iritis, and late complications can include optic capture, IOL decentration, haptic extrusion, and possible re-treatment.

Intrascleral haptic capture does have a learning curve, Dr. Hoffman explained. However, surgeons who have become familiar with the technique believe that it is easier to perform intrascleral haptic capture than suturing IOLs to the sclera.

**References**

2. Donaldson KE, Gorscak JL, Budenz DL. AC and scleral-sutured PC IOLs, and iris-sutured PC IOLs.
3. That study did not find sufficient evidence to suggest the superiority of one technique over another, Dr. Hoffman concluded.

**Surgeon's Advice**

As surgeons decide which approach is best for them, Dr. Hoffman had some advice.

“When approaching cases with no capsular support, surgeons should perform the procedure they are most comfortable with,” Dr. Hoffman said.

“However, surgeons should become familiar with the various available techniques as there may be instances where one procedure is better than another for a particular patient,” he added.

He also cited a study that reviewed the literature from 1980 to 2002 regarding IOL implantation in the absence of capsular support. The study supported the use of open-loop AC, scleral-sutured PC IOLs, and iris-sutured PC IOLs.

**Endnotes**

1. Richard S. Hoffman, MD

This article was adapted from Dr. Hoffman’s presentation during the 2014 meeting of the American Academy of Ophthalmology. Dr. Hoffman did not indicate any proprietary interest in the subject matter.
Warm viscoelastic eases IOL unfolding

Technique reduces flipping during rotation; works with other hydrophobic acrylic implants

By Cheryl Guttman Krader; Reviewed by Mitchell A. Jackson, MD

Dr. Jackson’s technique involves placing the viscoelastic syringes in their sterile packaging into an ultrasonic gel warmer. The device he uses has three temperature settings, but the lid of the device is always kept open to vent and prevent inadvertent overheating. Average temperatures range from 95° to 104°F (35° to 40°C). (Photo courtesy of Mitchell A. Jackson, MD)

Dr. Jackson

An ultrasonic gel warmer is used for the warming technique. There are three temperature settings, but the lid of the device is always kept open to vent and prevent inadvertent overheating. Average temperatures range from 95° to 104°F (35° to 40°C). (Photo courtesy of Mitchell A. Jackson, MD)

MITCHELL A. JACKSON, MD
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This article was adapted from Dr. Jackson’s presentation during the 2015 meeting of the American Society of Cataract and Refractive Surgery. Dr. Jackson is a consultant to Bausch + Lomb.
The study conducted by Dr. Nuijts and colleagues is in press in the Journal of Cataract and Refractive Surgery and is scheduled for publication in August 2015. It enrolled 28 patients randomly assigned to bilateral implantation with a trifocal diffractive MFIOL (FineVision MicroF, PhysIOL) or a bifocal diffractive MFIOL (AcrySof ReSTOR IQ +3, model SN6AD1; Alcon Laboratories).

The trifocal IOL distributes 45% of incoming light to distance, 20% to intermediate, and 35% to near (versus 59% to distance and 25.5% to near with the bifocal MFIOL) and features two superimposed bifocal patterns—one with a +1.75 D add and one with a +3.5 D add. The trifocal and bifocal MFIOLs evaluated in the study have similar negative asphericity of –0.11 and –0.10 μm, respectively (Figure 1).

No significant differences were found between the two groups of eyes in mean age or preoperative distance best-corrected visual acuity (BCVA). The refractive outcome at 6 months was also similar in the bifocal and trifocal groups (mean SE 0.11 and 0.03 D, respectively).

In binocular defocus curve testing, the trifocal group performed 0.16 logMAR better for defocus level –1 D (p<0.01, equivalent of 100 cm reading distance) and both groups achieved 0.2 logMAR or better in the range from 0 to –3 D. There was no significant difference between the two IOL groups in monocular uncorrected or distance corrected visual acuity at far, intermediate, or near.

However, the rate of complete spectacle independence was higher in patients with the trifocal MFIOL implanted than in the bifocal MFIOL group (80% versus 50%).

Results from contrast sensitivity testing under photopic and mesopic conditions showed the only significant difference between groups was at 6 cycles per degree under mesopic conditions. Data from the National Eye Institute Refractive Error Quality of Life Instrument-42 found no differences between the two implant groups in the quality of vision or perceived glare and halos.

**DATA FROM OTHER STUDIES**

Dr. Nuijts also reviewed data from three other published studies investigating the same trifocal MFIOL in larger groups of eyes (n = 40 to 198), a cohort study including 60 eyes implanted with another aspheric trifocal MFIOL (AT LISA tri 839MP, Carl Zeiss Meditec), and a randomized trial comparing the latter IOL with a bifocal diffractive MFIOL from the same manufacturer (AT LISA 801, Carl Zeiss Meditec).

The AT LISA tri 839MP distributes 50% of light for far, 20% for intermediate, and 30% for near. At the IOL plane it provides a near add of +3.33 D and an intermediate add of +1.66 D (Figure 2).

Dr. Nuijts reported that distance BCVA outcomes were similar for the two trifocal/bifocal MFIOLs across all studies. Distance-corrected intermediate visual acuity for the trifocal MFIOLs ranged from 0.06 to 0.17 logMAR and was significantly better with the trifocal MFIOL than the bifocal MFIOL in the direct comparison study (0.06 versus 0.30).

Dr. Nuijts also discussed in vitro research comparing the two trifocal MFIOLs, including...
a laboratory bench-based study evaluating through-focus modulation transfer function curves. Quality of vision was simulated using different sized apertures (2, 3, 3.75, and 4.50 mm) and changing diopters of defocus representing distance (0.0 D = 4 m), intermediate (~1.5 D = 67 cm), and near vision (~3/-3.5 D = 33/29 cm).

Results showed the FineVision MicroF trifocal IOL would provide better vision at distance in eyes with larger pupils (3.75 mm) compared with the AT LISA tri 839MP. However, the AT LISA tri 839MP had better results at intermediate and near focal points and was less dependent on pupil size.

A clinical trial comparing the FineVision MicroF and AT LISA tri 839MP IOLs in 30 patients who underwent unilateral implantation with the same lens found both trifocal MFIOLS were associated with excellent distance, intermediate, and near visual outcomes at 3 months. Statistically significant differences favoring the FineVision IOL were seen in analyses of distance-corrected intermediate and near visual acuity.

"Regrettably, because pupil diameter was not measured, it was not possible to assess the influence of pupil size on the in vivo results of this study," Dr. Nuijts said.

**TORIC, NON-TORIC MODELS**

A toric version of the FineVision trifocal MFIOL is also available in cylinder powers ranging from 1 to 6 D in 0.75-D steps, he noted.

A small unpublished study, which has been presented by Roberto Bellucci, MD, compared visual outcomes after bilateral implantation with the non-toric and toric versions of the FineVision trifocal MFIOL. It found no differences in uncorrected or distance-corrected visual acuity at near, intermediate, or distance. In the defocus curve, mean visual acuity was 0.2 logMAR or better from 1 to -3 D of defocus for both IOL types (Figure 3 on Page 14).
Preloaded IOL delivery system results in time savings per case, surgeon

Single-use approach also beneficial for reduced risk of infection and sterilization errors

By Nancy Groves; Reviewed by Guillermo Rocha, MD, FRCSC

BRANDON, MANITOBA, CANADA ::

**SIGNIFICANT REDUCTIONS** in total case time and surgeon lens time for a new preloaded IOL delivery system (Tecnis iTec, Abbott Medical Optics) were confirmed in a recent multisite time and motion study.

The study compared a manually loaded delivery system with the preloaded device, which was designed to improve efficiency in the operating room.

Third-party observers collected intraoperative time and motion data for all surgical staff before and after adoption of the system at three centers: a single-operating room set-up in Manitoba, Canada, where about 10 or 11 cataract procedures were performed per day; a two-operating room set-up in France, capable of handling about 18 cases per day; and a two-room site in Iowa where about 25 procedures could be performed per day.

A minimum of 20 cataract surgeries with manually loaded IOLs were performed, followed by training for the physicians and surgical staff on use of the system, then an additional series of surgeries using the preloaded device. About 154 surgeries were performed in all.

Guillermo Rocha, MD, FRCSC, GRMC Vision Centre, Brandon, Manitoba, Canada, performed all the surgeries at the Manitoba site; Jason J. Jones, MD, was the surgeon at the U.S. site, and Serge Zaluski, MD, performed the procedures in France.

The observers concluded that an average of 1.2 more cases per day could be performed at the Canadian site, which was a public hospital, according to Dr. Rocha.

To put this difference in perspective, Dr. Rocha explained that if he performed cataract surgery at this hospital once a week, that would equate to 4 more cases a month or about 48 extra cases a year without stretching the hospital’s resources or hiring additional staff.

“It may not sound like much, but when we’re dealing with waiting lists (for surgery), any little bit that we can do is definitely significant,” Dr. Rocha said.

He also noted that performing the additional cases would result in little if any additional cost to the hospital system, since the operating room staff would already be on duty and paid for their time, and one additional case per day would not put undue pressure on the team.

**IMPROVED EFFICIENCIES**

The data analysis from the three sites showed that capital and labor cost efficiencies resulting from additional throughput reduced the mean cost per case by an estimated 2.4% in France and 4.2% in Canada. The revenue implications of additional throughput in the United States were estimated to increase profit by 5.3%. Time savings due to improved throughput were a gain of 4% in the United States, 5.7% in France, and 9.9% in Canada.

Dr. Rocha described the preloaded system as standard and almost “foolproof”—one that could be completed in three steps: injection of viscoelastic and cap removal, pushing the plunger to the dwell position, and depressing the plunger to insert the lens.

No time is wasted because the lens is loaded while the ophthalmologist is completing the surgery, he explained.

A second benefit, which also helps improve efficiency, is that the device is a single-use system. The nurses do not have to remove the cartridge, clean the inserter, and send it to another department for sterilization, as with a reusable device. This also reduces the risk of infection or sterilization errors.

In addition, surgeons do not have to touch the lens, which could cause damage or contamination. Since the lens is encased in a disposable cartridge and inserter, there is minimal contact with the exterior as well.

“It’s a cleaner way of delivering the lens without it being exposed to any potential contaminants,” said Dr. Rocha, adding that the amount of contact with the lens was not an aspect of the study but rather his personal observation.

“For me, the most important thing was having a consistent and predictable way of delivering the lens, not wasting time preparing the lens and loading it but having it ready,” Dr. Rocha said. “Just as soon as I’m done, the nurse passes it to me and I inject it. That really has made my operating room days more efficient.”

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**GUILLERMO ROCHA, MD, FRCSC**

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Dr. Rocha serves on the advisory board for Abbott Medical Optics (AMO) and is also a consultant and has received speaker honoraria. However, he did not receive any funding from AMO for this project, which was required as part of his relationship with the hospital where the study took place.
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**AAO issues statement regarding study linking Ebola and uveitis**

**THE AMERICAN** Academy of Ophthalmology (AAO) has issued a statement following a report in the *New England Journal of Medicine* about an Ebola patient with uveitis.

“The medical community has appreciated the need for an extra procedure preoperatively and the potential complications that can occur with iridotomy/iridectomy,” Dr. Mertens said. “By creating more natural aqueous flow, they also reduce the risk of lens opacification.”

“During follow-up that ranges up to 3 years in a series of 569 eyes with the [device] implanted, I have seen no cases of lens opacification,” he added.

Other design modifications include extension of the axis alignment markings on the toric version, which makes accurate orientation easier and enables postoperative assessment of the phakic IOL’s position, he noted.

In addition, the lens is stored in balanced salt solution rather than saline, so that it is fully hydrated.

**REFRACTIVE OUTCOMES**

Results from follow-up to 1 year for 306 eyes with the lens implanted for myopia or myopic astigmatism show it provides predictable, safe, effective, and stable refractive correction. The patients, all operated on by Dr. Mertens, had a mean age of about 32 years, mean sphere of about –6 D (range –0.75 to –14.75 D), and mean cylinder of about –1 D (range 0 to –4.25 D).

Achieved spherical equivalent (SE) almost perfectly matched the attempted correction, and at postoperative follow-up visits conducted at 1, 3, 6 and 12 months, SE was plano in 96% to 99% of eyes. Mean SE was 0.02 D at 1 month and was stable at 0.01 D at all subsequent follow-up visits.

Uncorrected visual acuity (UCVA) and best-corrected visual acuity (BCVA) at 1 year were better than preoperative BCVA. UCVA was 20/20 or better in 97.3% of eyes and 98.6% had BCVA of 20/20 or better.

Safety was excellent as well. No eyes lost BCVA and about 40% gained 1 or more lines. There were no cases with pupillary block or increased IOP.

Data from optical coherence tomography measurements of vault at the center of the ICL showed that the clearance distance decreased during the first year and then stabilized. Mean vault at 1 year was about 410 μm, but the vault was <100 μm in 23 eyes.

As the device design provides a more natural flow of aqueous, the lens can tolerate a much lower vault, Dr. Mertens said.
Cataract surgery is an opportunity to give your patients vision for their life ahead. True to that, Bausch + Lomb’s innovative technologies focus on long term vision that can help you achieve outstanding outcomes and continued practice success.
Approaches to toric IOL alignment reflected in clinical trends, practice

Surgical technique also plays a role in the stability and performance of lenses

By John A. Vukich, MD, Special to Ophthalmology Times

**TECHNOLOGICAL ADVANCES IN IOLs**

**Approaches to toric IOL alignment reflected in clinical trends, practice**

Surgical technique also plays a role in the stability and performance of lenses

**WHEN IT COMES TO addressing astigmatism in patients with cataracts with ≥1.25 D of astigmatism, implanting a toric IOL is the most common approach.**

Consider that toric IOLs were implanted in 19% of cataract surgery procedures, according to the 2014 American Society of Cataract and Refractive Surgery Clinical Trends Survey—to which more than 1,500 surgeons responded.

In addition, with several new toric IOLs in the marketplace, this category has been growing rapidly and has much room for expansion—given that about 37% of the population has ≥1 D of astigmatism.

In this surgeon’s hands, toric lenses are more predictable and more consistent at achieving the desired results than incisional correction at 1 D or greater of astigmatism. At lower levels (1 to 1.5 D), it is a reasonable decision to sacrifice some of the predictability of a toric IOL for the convenience and cost-effectiveness of incisional correction, especially if patients are interested in spectacle independence at near.

Good candidates for a toric IOL include patients who desire good uncorrected distance vision and are comfortable with wearing spectacles for near. Topography is essential to determining that astigmatism is regular and stable and there is no significant corneal disease affecting the ocular surface or shape.

It is important to ensure that the best astigmatic correction of an irregular cornea—i.e., one with pellucid marginal degeneration, keratoconus, or forme fruste keratoconus—is not substituted for the true axis of astigmatism.

Among good candidates, there is potential for error in selecting the axis or magnitude of astigmatism and in correctly aligning the IOL in the eye. For every degree the lens is rotated off-axis, there is a 3.3% loss of effectiveness of the toric IOL power.

For best results, the IOL should be within 5˚ of the intended axis, especially when implanting higher-power toric lenses. Despite this, survey respondents indicated that an average 7.2˚ of rotational error would be acceptable, with about one-third of respondents being comfortable with rotational error of 10˚ or more.

**DETERMINE MAGNITUDE, AXIS**

Accurate identification of the magnitude and axis of astigmatism is essential in order to choose the right toric power and correctly position it. However, there is no strong consensus about which measurement is the best one on which to base magnitude and axis decisions.

In the survey, IOLMaster Ks were most commonly used to determine magnitude, followed by topography and manual Ks. Topography is most heavily relied upon for axis determination, with IOLMaster and Lenstar following. Other methods—including autokeratometry and intraoperative aberrometry—are also used.

Though these are all good methods, ideally, one should have at least two different measures from two different devices. Because each device measures slightly differently, the Ks are unlikely to be identical, but close agreement should be sought and significant differences
among measurements should be reconciled to avoid power calculation or axis errors.

In selecting the best lens power, it is perfectly acceptable to flip the axis, even though nearly one-half of surgeons say they never do this.\textsuperscript{1} The conventional wisdom not to flip the axis is based on incisional techniques, when an axis shift could not be reasonably controlled and might result in a large and poorly tolerated error in the opposite axis.

However, with an optical lens solution that does not involve relaxing the cornea, surgeons have more control. If the choice were between leaving 0.50 D of residual error at the original axis or 0.10 D at the opposite axis, it would be preferable to flip the axis. The amount of residual error is so small that it will be easily tolerated.

**MARKING THE AXIS**

Survey results demonstrate there is also considerable variation in how surgeons mark and align toric IOLs.\textsuperscript{2}

Thirty-seven percent say they rely on anatomical landmarks without marking the cornea or only mark the major axes preoperatively without using any additional axial marking tools during surgery (Figure 1 on Page 20). For accurate placement, the latter is required, at a minimum.

Ideally, the principal meridians should be marked preoperatively with the patient in a seated position, and the axis marked intraoperatively with the aid of an axial tool. A fine, durable mark that does not wear off or subside more than a few degrees should be made.

The initial meridian marks can be used as a point of reference intraoperatively, with the patient lying down, to accurately mark the axis of astigmatism even if some cyclorotation has occurred. A Mendez ring or other axial ink marker (one that leaves a fine, durable mark) will be more accurate than surgeons’ estimation of the axis in relation to the principal meridians.

Other marking techniques have been developed and shown to be quite accurate. For example, Robert Osher, MD, has described a thermal device that leaves a fine mark. Others have used a Nd:YAG laser to pit the epithelium at the limbus or a sterile needle to create a linear superficial abrasion that can be stained with fluorescein or another dye to highlight the mark.

Advanced devices—such as intraoperative aberrometry or surgical guidance systems that incorporate digital registration—are not necessary for implantation of toric IOLs, but they do add greater precision for surgeons who want to maximize outcomes.

**ALIGNING THE LENS**

For implantation of the IOL, it is important to choose a rotationally stable toric lens. Unless a very high-powered toric lens is needed, this surgeon’s personal preference is a certain toric IOL (Tecnis Toric, Abbott Medical Optics). The platform offers predictable, high-quality performance in general, including excellent stability. In clinical studies, the mean change in axis between baseline and 6 months was just 2.74°, indicating good lens stability within the capsular bag.\textsuperscript{3}

Ninety-three percent of eyes with this lens implanted had a change in axis of ≤5° between two consecutive visits about 3 months apart.

Continues on page 27: Alignment
BAKERSFIELD, CA ::

**NEW LOW-ADD VERSIONS** of the 1-piece multifocal IOL (Tecnis Multifocal, Abbott Medical Optics) afford cataract surgeons an opportunity to customize selection of the presbyopia-correcting IOL according to a patient’s vision needs. In addition, they appear to have the potential to minimize halos, which are intrinsic to multifocal optics, said Daniel H. Chang, MD.

Dr. Chang presented results from the FDA study investigating the +2.75 D and +3.25 D add versions of the hydrophobic acrylic, aspheric diffractive multifocal IOL (models ZKB00 and ZLB00, respectively).

The theoretical reading distances for the +2.75 D, +3.25 D, and original +4.0 D add models (ZMB00) are 50, 42, and 35 cm (20, 17, and 13 inches), respectively. The low-add IOLs are based on the same spherical aberration-correcting design and chromatic aberration-minimizing material as the +4.0 D add model.

A full diffractive surface provides quality vision and pupil independence with equal light distribution between distance and near, explained Dr. Chang, who was an investigator in the FDA study and is in private practice, Empire Eye and Laser Center, Bakersfield, CA.

**ABOUT THE STUDY**

The FDA study was a prospective, multicenter, bilateral, open-label, evaluator-masked, modified parallel group clinical trial. It enrolled 445 patients who received either the +2.75 D add multifocal IOL, the +3.25 add multifocal IOL, or the 1-piece aspheric monofocal version (Tecnis IOL, ZCB00).

Results from testing performed at 6 months after the second eye surgery showed patients in the low-add multifocal IOL groups achieved comparable distance vision relative to the controls that received the monofocal IOL.

However, the low-add multifocal IOL groups benefited with a >3-line improvement in near visual acuity, increased spectacle dependence, and a higher level of satisfaction with their uncorrected vision.

All three versions of the multifocal IOL “are great options as each can provide comfortable uncorrected vision at distance, intermediate, and near in more than 80% of patients,” Dr. Chang said. “However, with the two new low-add versions, I can now provide patients with a personalized best range for near and intermediate vision.”

He added that relative to the original +4.0 D add Tecnis multifocal IOL, the low-add versions seem to be associated with fewer night-vision complaints and halos in particular.

**STUDY DESIGN, TESTING**

Patients enrolled in the FDA study chose the lens type to have implanted based on consideration of their needs for near and intermediate vision and assessment of their preferred reading distance.

At 6 months, over 99% of patients enrolled in the study were available for evaluation. In binocular testing, mean logMAR distance uncorrected visual acuity was similar in the control, +2.75 D add, and +3.25 D add IOL groups (–0.01, 0.01, and 0.02), and there was also no significant difference between groups in mean logMAR best-corrected visual acuity at distance (–0.09, –0.07, and –0.06).

However, compared with the control group, patients with the +2.75 D add +3.25 D add IOLs implanted had significantly better uncorrected visual acuity was similar in the control, +2.75 D add, and +3.25 D add IOL groups (–0.01, 0.01, and 0.02), and there was also no significant difference between groups in mean logMAR best-corrected visual acuity at distance (–0.09, –0.07, and –0.06).

Analyses of directed reports of optical/visual symptoms showed none of the patients in the control group was completely spectacle-independent, whereas 61.3% of patients with the +2.75 D add IOL implanted and 75.0% of those with the +3.25 D add IOL implanted said they never wear glasses.

Almost one-third of control patients said they either wore no glasses for near or wore
them less than half the time, and those levels of spectacle independence were achieved by nearly 90% of patients in both of the multifocal IOL groups. Overall satisfaction with vision without glasses was expressed by 85.6% of controls, 97.2% of the +2.75 D add patients, and 93.3% of +3.25 D add patients.

In response to direct questioning, moderate to severe difficulty with halos was reported by 16% of control patients, 31% of patients with the +2.75 D add IOL, and 43% of those with the +3.25 D version. There was less of a difference between the control and +2.75 D and +3.25 D add multifocal IOL groups in rates of moderate to severe difficulty with glare/flare (19% versus 23% and 31%).

When specifically asked about difficulty with night vision, fewer patients had moderate to severe difficulty with night vision in the +2.75 D add multifocal group than in the +3.25 D add multifocal and even the control group (9% versus 16% and 14%, respectively).

“Within 1 to 2 weeks after surgery, patients with the low-add . . . multifocal IOLs had little problems with halos and night vision,” Dr. Chang said. “This rapid neuroadaptation phase seems to occur especially with the +2.75 D add version. For that reason, more-demanding patients may particularly benefit from that lens.”

The new low-add versions also offer an opportunity for customizing implant decisions using a different add power of the multifocal IOL in the second eye, if indicated by patient preference after the first eye surgery.

“Almost all patients are very happy with their vision after the first surgery and go on to receive the same IOL in the fellow eye,” he said. “Occasionally, however, someone desires a slightly different profile of near and intermediate vision.”

This type of variation in near focal points can occur unintentionally when implanting the same add multifocal IOL in both eyes as the result of a slight difference in refractive outcomes, Dr. Chang noted.

“We know that patients typically do fine in that situation, and sometimes we even did that intentionally,” he said. “Now with the different versions of [this] multifocal IOL we can approach this type of customization while still targeting a plano refraction in both eyes for the best distance vision.”

DANIEL H. CHANG, MD
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This article was adapted from Dr. Chang’s presentation at the 2015 meeting of the American Society of Cataract and Refractive Surgery. Dr. Chang is a paid consultant for Abbott Medical Optics.

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Stein Eye Institute and Doheny Eye Institute join forces to improve patient access to top vision specialists.

Two of the nation’s top eye institutes have united in an affiliation that will improve patients’ access to leading vision specialists. UCLA Stein Eye Institute and the Doheny Eye Institute — both created by families whose legacies helped shape Los Angeles — have joined forces to offer the best in patient care, vision research and training for future eye specialists. The affiliation adds 14 clinicians and researchers from Doheny to the ophthalmology faculty at the David Geffen School of Medicine at UCLA.

Patients can be seen at Doheny Eye Center UCLA offices in Pasadena, Arcadia and Orange County.

Both institutes have earned international recognition for the quality of their patient care and research. U.S. News & World Report’s 2015 “Best Hospitals” survey ranked the combined Stein Eye and Doheny Eye institutes as the No. 5 center for ophthalmology based on feedback from specialists in the field.

UCLA Stein Eye Institute is a vision science campus dedicated to the preservation and restoration of vision through its internationally recognized programs in research, patient care and integrative education. The center’s ophthalmic specialists treat the full spectrum of vision-threatening conditions, including glaucoma; macular degeneration; diseases of the cornea, retina and vitreous; cataracts and uveitis; intraocular inflammation; Graves’ disease; ptosis and lacrimal disease; and eyelid disease.

Community outreach efforts range from its mobile eye clinic, which travels to schools, shelters, health fairs and other organizations that assist homeless and low-income families; to programs like Vision IN-School, for vision education; Shared Vision, for the collection and donation of used eyeglasses; the Preschool Vision Screening program; and the Indigent Children and Families program.

The Doheny Eye Institute, established in 1947, is a top-ranked nonprofit organization dedicated to the conservation, improvement and restoration of human eyesight. Recognized as an outstanding center for vision research and education, the Doheny Eye Institute has emerged as a world leader in basic and clinical vision research. The institute’s innovative research has led to new diagnostic and treatment procedures and is internationally regarded for changing people’s lives by improving their sight.
UCLA Stein Eye Institute and Doheny Eye Institute have joined forces to offer the best in patient care, vision research and education. This affiliation combines the strength, reputation and distinction of two of the nation’s top eye institutions to advance vision research, education and patient care in Southern California.

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PRODUCTS & SERVICES
Enhanced injector for hydrophobic acrylic IOL yields greater control
Updated device has longer plunger with polished, softened plunger tip to reduce resistance

By Nancy Groves; Reviewed by Anil M. Shivaram, MD

CLAREMONT, CA ::
A SERIES OF SMALL modifications to a lens injector system (BLIS Injector System, Bausch + Lomb)—designed for use with a glistening-free hydrophobic acrylic IOL (en-Vista, Bausch + Lomb)—add up to huge improvements compared with the original system, said Anil M. Shivaram, MD.

“The previous iteration of the delivery system was not as optimized as it could be in terms of the delivery of the lens,” said Dr. Shivaram, an ophthalmologist in Claremont, CA, who has performed more than 80 procedures with the recently released updated injector. “I think [the manufacturer] was getting feedback from myself and a number of other surgeons that they wanted to maximize the utility of the delivery system with the idea that eventually there will be an array of lenses that can be used with it.”

NEW FEATURES
One change is a longer plunger. With the additional 2 mm of length, it is easier for the surgeon to “dunk” and manipulate the lens when it is in the capsular bag, according to Dr. Shivaram.

The modified injector also has a polished, softened plunger tip to reduce resistance between it and the lens.

Though the previous version of the injector system was left-biased to increase compression on the haptic, the plunger tip has been repositioned and centered to instead reduce pressure in the optic-haptic junction. A slight downward angulation has been added to make sure the trailing haptic stays within the folded portions of the optic but without creating stress on that junction.

The external finish was also changed to provide more tactile feedback, a feature many surgeons appreciate, Dr. Shivaram said.

With any lens injector system, surgeons can potentially lose control of the lens. This can happen, for example, when there is too little viscoelastic in the cartridge, causing air pockets and forcing the lens to express faster than expected into the eye. The updated device ensures controllable, repeatable deliveries with little to worry about, he noted.

“It allows for minimizing that uncontrolled delivery,” Dr. Shivaram said. “You get a nice, smooth delivery of the lens without placing a lot of tension on the optic-haptic junction.”

The injector can be used through incisions as small as 2.2 mm, he noted.

Based on his experience with the new system, the changes have optimized delivery of the lens, Dr. Shivaram said.

Although currently only used with one IOL model, the recent improvements in the injector system and any future modifications could eventually extend its utility to an entire family of lenses, he added. ■

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ALIGNMENT

(Continued from page 21)

meeting ANSI criteria for toric lens stability.3 This translates into excellent visual acuity results (Figure 2 on Page 20).

Surgical technique plays a role in the stability and performance of toric IOLs as well. I prefer to use a cohesive viscoelastic. It is important not to over-pressurize the eye. The lens can be injected counterclockwise of its final position and then dialed into correct alignment with the axis marks. Once aligned, I push the IOL gently against the posterior capsule.

Finally, all of the ophthalmic viscosurgical device must be carefully removed from behind the lens.

With this approach of careful preoperative measurement and marking, intraoperative marking and alignment, and good surgical technique, surgeons can achieve success with toric IOLs to the benefit of their practices and their patients with astigmatism. ■

References

JOHN A. VUKICH, MD
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Dr. Vukich is surgical director, Davis Duehr Dean Center for Refractive Surgery, Madison, WI. He is a consultant to Abbott Medical Optics.
Fluid-filled accommodative IOL shows stable visual function over 18 months
Lens design exhibits ‘true accommodation’ in pilot study; moves into multicenter study

By Lynda Charters; Reviewed by Louis D. “Skip” Nichamin, MD

A NOVEL FLUID-BASED AVALON, CO::

Dr. Nichamin, in private practice in Avon, CO.

mechanism of accommodation, according to Dr. Nichamin, who is a medical advisor to PowerVision.

“True accommodation is defined as the ability to see at near and distance seamlessly and to maintain the natural mechanism of accommodation, according to Dr. Nichamin, in private practice in Avon, CO.

PILOT STUDY

The pilot study enrolled 20 patients with the lens implanted at one site in Pretoria, South Africa. Two surgeons performed all of the monocular implants. Patients were followed at 1 day, 1 and 2 weeks, and 1, 3, 6, 12, and 18 months postoperatively to evaluate the accommodation and accommodative amplitude.

The study evaluated refining the implant technique, selecting and refining the accommodation measurement techniques, and demonstrating the safety of the lens.

At 6 months postoperatively, all patients had excellent distance best-corrected visual acuity (average, 20/19) and very good intermediate and near visual acuities of 20/26 and 20/33, respectively. Visual acuity remained stable out to 18 months in the study patients, Dr. Nichamin noted.

The average accommodation by the “push-down method” was 3+ D, as was its defocus range. Both of these measurements remained stable throughout the follow-up period. Patients also showed an average of 2.5 to 3 D of accommodation when induced by pilocarpine.

Measurement of visual acuity in a small subset of patients who underwent binocular implantation showed an average of one additional line increase in best distance-corrected near and intermediate visual acuity, according to Dr. Nichamin, who is a medical advisor to PowerVision.

“No clinically relevant complications were associated with the implantation of the IOL,” he said. “Implantation of this accommodative IOL is comparable to a standard IOL implantation procedure.

“The objective accommodation met the International Organization for Standardization guidelines to be labeled an accommodative IOL and subjectively, the patients who are best-corrected for distance see far, intermediate, and near and can read without supplemental correction,” Dr. Nichamin said.

The excellent distance refraction demonstrates the high optical quality of the lens, according to Dr. Nichamin.

MULTICENTER STUDY

The multicenter study—being performed at seven centers in South Africa and Germany—began in January and April 2014, respectively, with a goal of completing 115 implantations.

In South Africa, phacoemulsification was performed with manual curvilinear capsulorhexes (CCCs).

In Germany, the procedures are being performed with both manual CCCs and femtosecond laser. Sixty-eight of the 115 implants were completed with 4-mm insertion, and the remainder will be performed with a 3.5-mm insertion system.

LOUIS D. “SKIP” NICHAMIN, MD

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Dr. Nichamin is a medical advisor to PowerVision Inc. and has no financial interest in any surgical instrument mentioned in this report.

About the lens design

> Optic diameter: 6.0 mm
> Overall diameter: 10 mm
> Haptics height: 3.0 mm
> Refractive index = 1.48
> The optic is suspended between the haptics

The lens body of the fluid-based accommodative technology is made from hydrophobic acrylic. The lens and hollow optics are filled with index-matched silicone fluid. Movement of fluid from the haptics to the optic produces large increases in optical power. (Figures courtesy of Louis D. “Skip” Nichamin, MD)

About the technology

As background, the body of the lens is made from a proprietary hydrophobic acrylic. The lens and hollow haptics are filled with a proprietary index-matched silicone fluid.

The act of accommodation forces fluid from the haptics into the optic, which increases the optic thickness and optical power. During disaccommodation, the fluid flows back into the haptics and the optical power decreases.

The lens is 10 mm in overall diameter with an optic that is 6 mm in diameter. The haptics are 3 mm high and the refractive index is 1.48. In this IOL, the optic is suspended between the haptics.

The lens is an investigational device and is not available for sale or use in the United States.
Putting It In View

A lesson from the sports world: Sometimes good for all is better than perfect for one

Running a ‘perfect’ clinic

A lesson from the sports world: Sometimes good for all is better than perfect for one

Taking It In View

By Dianna E. Graves, COMT, BS Ed

I can be considered a “sportsaholic”—no matter what season of the year, I will be fixated on a sport and the teams/politics involved. Baseball owns my heart. While most folks bravely trudge through one Fantasy Baseball team, I proudly manage three!

Every morning on my way to work, I am glued to the radio—making sure to get the latest updates on the games played last night and the pundit’s philosophies of the teams in question.

One show I listen to is the “Mike & Mike” Show, with Mike Greenberg and Mike Golic. They have good banter, comedic discussions, and excellent analysis of sports. Greenberg plays the absolute antithesis of a “rough-and-tumble athlete,” and Golic is the ex-football player who “has done all that.”

One day, they were having a passionate discussion of a recent game, and Greenberg called out in angst the following statement:

I thought back on this statement periodically throughout the week, and began to have an understanding of what Greenberg might have meant as it related to my world.

We have recently changed lead technicians/lead locations in six of our clinics, and while it has gone relatively smooth in the past month, I am beginning to see the “shine” wear off.

When you make a large clinic change, there will be a grace period where tolerance of all the staff will be high. Misjudgments, miscalculations, overreactions to situations, and napoleonic behavior is often overlooked or diminished, and all sins are quickly forgiven. This can also be called the “honeymoon period.”

Shawn, my new “right-hand” lead, informed me of this spur-of-the-moment sick call. Using this as a teaching moment for Shawn, we began reviewing the situation and what it meant throughout the system:

1. We needed to look at other four clinics and the dynamics of those clinics, and also the clinic that was now short... as well as the lead running that clinic.
2. We looked at the dynamics/deemjor of the physicians at the short clinic.

I decreed that one of the technicians, Sara, needed to leave Shawn’s clinic and go to the clinic that was now short. Shawn was to inform Sara, and the case was closed. Or so I thought.

Fifteen minutes later, Shawn called to tell me that instead of sending Sara, she had sent Peggy.

I was angry for a number of reasons, but tried to temper this so I could try and help Shawn understand the many errors of her ways. She felt she had made an educated decision. While it was educated—it was also ill timed, slightly ulterior, and poorly executed.

Peggy is a sweet-tempered and patient technician, but she is newer and still slow with her skills. Going into that fast-paced, crazy clinic was not what I had envisioned. Basically, it was a very poor move and it set Sara up for a pretty scary morning.

Continues on page 30: Clinic

OT columnist Grande joins Wells Fargo ‘Premier Advisor’ program

OAKHURST, NJ ::

WELLS FARGO Advisors Financial Network has designated John S. Grande, CFP, registered principal, as a member of the firm’s Premier Advisors Program.

The distinction reflects Grande’s achievement of professional success by meeting or exceeding Wells Fargo Advisors Financial Network’s high standards as measured by one or more of the milestones for revenue generation, educational attainment, and client-service best practices, said Wells Fargo in a prepared statement.

Grande is a long-time contributor to Ophthalmology Times’ “Money Matters” column, along with father, John J. Grande, CFP, and mother, Traudy F. Grande, CFP. In addition, Grande has been published in numerous medical journals and has lectured at Johns Hopkins University School of Medicine, Baltimore, as well as other medical associations.

He has been a financial advisor with Wells Fargo Advisors Financial Network for 3 years and has 20 years’ experience in the brokerage industry. Grande holds a bachelor’s degree in business and economics from Lehigh University, Bethlehem, PA.
CLINIC

(Continued from page 29)

WHAT WENT WRONG?
While you might feel it is good to have the lead thinking ahead, what she really did was:

- Look at how her clinic was being slightly stretched, and decided to keep the strong technician (Sara) that I was sending away and instead sent the “weaker” technician (Peggy)—thereby, her clinic remained strong and “excellent.”
- Involve two other clinics (making a complicated four-way switch versus just a simple two-way switch). Now there were technicians all over the road in the early-morning, rush-hour traffic.
- Put a new person, who was being sent to “save the day” in the potential line of fire.
- Override me, and then informed me of it after the fact. There was no changing it after it was done.

Throughout the day, a discussion commenced of where Shawn had gone astray, my perception of why she did this, and the errors of her thinking.

I absolutely need and want her to be thinking and making decisions, but in a global manner not an individual manner, thereby ensuring her clinic world was running perfectly.

Instead of everyone having a chance to run “good” on this crazy morning, she jet-tisoned two clinics so they ran minimally “fair” and then ensured her clinic ran perfectly. Sometimes good for all is better than perfect for one.

The leads/managers will begin to do things quietly below the radar to ensure their clinics run smoothly, and that they remain basking in the glow of success, even if it is at the downfall of someone else. This cannot be allowed to occur.

THE BIG PICTURE
Managers/leads need to be thinking constantly of the whole picture and not just the small, individual frames of snapshots.

I am not saying these are heinous, pre-mediated acts to tank other leads—because they aren’t. It is human nature to survive, and to them, they are simply surviving. You may see another example in this instance:

Every time you call a clinic, Angie, a general technician, answers the phone instead of the lead technician. When you ask where the lead is, you are told that he or she is in a room seeing a patient. When you ask the lead why the general technician is always answering the phone or the physician’s bell, the reply will be: “We were behind, and I am faster than them, so I had them ride the desk.”

Instead of correcting, mentoring, and advising Angie to improve her speed, the lead “hides” her at the desk and pushes her to the side. All is well, but Angie is failing.

Lastly, there are going to be times when all hell is going to break loose. It happens!

Help the leads understand it is just a ripple in the water, and help them learn how to get out of the nightmare day they are having. Teach them how to raise the white flag and how to reassess what has occurred.

Being oblivious to it, or trying to hide it, is like putting a pink dress and high heels on a grizzly. While you may be able to dress it up, you still have an angry bear running around in the clinic.

When I return from the weekend, Shawn and I will need to go have breakfast and discuss why she received my wrath. We will discuss that while “good” would have been the best outcome for all involved, she had basked in the glow of “excellent” at the sake of her fellow technicians.

I am sure there will need to be a Bloody Mary involved as the first course—at least for me! ■

‘Managers need to be thinking constantly of the whole picture and not just the small, individual frames of snapshots.’

— Dianna E. Graves, COMT, BS Ed

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**References**


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