Co-Managing Advanced Technology IOLs

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Professional Disclosures

- Alcon: Advisory Board, Research, Speaker
- Allergan: Research, Speaker
- Bausch & Lomb: Speaker
- Inspire: Allergy Advisory Board, Research, Speaker
- Ista Pharmaceuticals: Research
- Pacific University: Adjunct Assistant Clinical Professor
- Pennsylvania College of Optometry: Externship Coordinator
- Science Based Health: Research
- Southern California College of Optometry: Externship Coordinator
- Vistakon: Speaker

Today's Optometrists

“To be on the cutting edge of optometry, you need to be on the cutting edge of science and technology.”

- Christine Sindt, OD

Co-managing Advanced Technology IOLs

- This is your new refractive surgery patient!!
- Advanced technology
- Successful outcomes
- OD Co-management

Pearls on Optometric Comanagement

- Get to know your surgeon
- Convey patient preferences, observations and conditions to your surgeon
- Inform your patients on your role in peri-operative care
- Successful co-management is the result of continuous communication

Why Become Involved?

- 3 million cataract surgeries each year1
- By 2020 the U.S. population over 65 will double from current levels – 12.9% of total population
- HCFA allowing surgeons to bill for non-covered services
- Tangible vs. Intangible benefits

Basic Marketing Concepts

- Needs / Wants / Demands are underlying concepts of marketing
  - Needs are basic requirements of human beings
  - Wants are the form human needs take as they are shaped by culture and individual personality
  - Demand is want backed by buying power

- Patients need to see, want freedom from glasses, and have the means to invest in technology

The Baby Boomers

- Baby Boomers represent the generation with the greatest buying power in the history of our country
- Account for a dramatic 40% of total consumer demand – even in a recession
  - Find a way to appeal to us through our desire to stay young, act young, think young and feel young
- Have more discretionary income than any other age group
- Watch TV / read newspapers more than any other age group

Optometric Opportunity

- Maintain a refractive mindset
- Direct to consumer advertising is coming
- Who better to hear about these options from than their own optometrist?

The Cost of Lifestyle IOLs

- People want food, they buy it
- They want a house, they pay a mortgage
- No matter where they go, people pay for the products they receive
- Price should be transparent
- Must show them value

Prescribing From Your Chair

- We do it for optical goods
- Know the products thoroughly
  - Advantages / Disadvantages
- Know our patients
  - Listens, ask questions, understand needs
- Believe in the technology
  - Delivers outstanding results to patients

Advanced Technology IOLs: The Optometrist’s Role to Success

- We understand our patient’s needs
- We know the differences in premium IOLs
- Patient education is the crucial
- Communication is the key to successful co-management
Understanding Patient Needs

• What area of vision is most important to you?
  – Distance
  – Intermediate
  – Near

Vision After Cataract or Refractive Surgery in the Presbyopic Patient

• Improve the quality of life of our cataract patients by increasing their spectacle freedom through providing a quality range of vision
  1. Monofocal at distance (near glasses)
  2. Monofocal at near (distance glasses)
  3. Monovision (successful with contacts)
  4. Toric (monofocal)
  5. Multifocal

Who Are Good Multifocal Candidates?

• Visual and functional need for cataract surgery
• Motivated not to wear glasses
• Younger or Young at Heart patients*
• Active lifestyle
• Qualify for bilateral implants
• Realistic expectations

Who Are NOT Good Candidates for Multifocal IOLs?

• Those who want to wear glasses
• Poor “general alertness”
• Occupational night drivers
• High astigmatism*
• Poor candidates for refinement
• Unrealistic expectations
• Ocular pathology

* Relative Contraindications
Patient Selection is Key

Patient Selection Pearls

- Realistic expectations
- If you suggest a multifocal for a perfectionist don’t be surprised when they demand perfection
  - Multifocals do not fix crazy patients

Patient Questionnaire

Pupil Considerations

- **Small**
  - ReSTOR
  - Rezoom

- **Medium**
  - Most IOLs fine

- **Large**
  - ReZoom—greater halos
  - ReSTOR—minimizes halos at night

- Pupil Independent
  - Tecnis MF and Crystalens

Ocular Pathology

What About Astigmatism?

- Quality of vision
- Pre-surgical aberrations tolerated
- More adapting issues post-surgical

No Astigmatism  1.0 D Astigmatism  2.0 D Astigmatism
Addressing Astigmatism

• Patient’s understand astigmatism
• Know the importance of treating their “stigma”
• This “stigma” gives them problems with their glasses or contacts

Setting Expectations

• Individual patient perceptions vary
• Best vision after bilateral implantation
• Glare/Halos
• Lighting considerations
• Possibility of refinement

Under Promise…. Over Deliver

• Tell the patient that they are still going to have to wear glasses with any IOL option
• Tell patients that they will see rings around lights with a multifocal IOL

Differences in IOLs Technology

How Do These Compare?

<table>
<thead>
<tr>
<th>IOL Materials</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMMA - 10%</td>
<td>LT experience, Good biocompatibility, Cheap</td>
<td>Large incision, Pits with laser, High incidence of PCO</td>
</tr>
<tr>
<td>Silicone - 30%</td>
<td>Foldable – small incision, Fairly low incidence of PCO</td>
<td>Pits with YAG laser, Rapid unfolding, Dislocation after YAG, More decentration, Anterior capsule contraction, Slippery when wet, Cannot use with silicone oil</td>
</tr>
<tr>
<td>Acrylic - 60%</td>
<td>Foldable – small incision, Fairly low incidence of PCO, High refractive index</td>
<td>Tacky surface, Difficult to undo, Glistening, Glare</td>
</tr>
</tbody>
</table>

IOL Materials

Accessed from www.allaboutvision.com on 4/7/11

Taken from http://www.optometry.co.uk/articles/docs/c61abd5f535b595ad793073458afed7c_hollick20011102.pdf on October 10, 2009
**Single-Piece vs. 3-Piece IOL**

- **Stableforce haptic** is stronger...500% more tensile strength than PMMA
- A 3-piece IOL loses its decompressive force with time...optic may vault forward
- Stability...maintains positioning in the bag

**Why ACRYSOF® Natural?**

- **Why filter 400-500 nm light?**

**Spherical Aberration**

- Spherical aberration occurs when marginal rays are over-refracted, resulting in a region of defocused light which can decrease image quality.

**Quality of Vision**

**Spherical Aberration**

**Aspheric Correction**

[Images of optical test charts illustrating the difference between spherical aberration and aspheric correction]

**AcrySof® IQ Platform**

- Acrylic
- Single piece
- Blue light filter
- Aspheric design
- The IOL used routinely at the Virginia Surgery Center for monofocal correction

**Advanced Technology: The Players**

[Images and logos of various companies and technologies related to eye care]
**Toric IOLs**

- Differentiate corneal cylinder from refractive cylinder
  - Corneal
  - Lenticular
  - Mixed

- Accurate / consistent measurements
  - Manual keratometry
  - Corneal topography
  - IOL Master

**Case Example**

- 62 year old white male
- MRx
  - -5.75 + 5.25 X 177 20/20
  - -5.25 + 5.25 X 165 20/20
- Ks
  - 43.25/46.25 @ 003
  - 43.00/45.75 @ 176
- Pachy
  - 604um
  - 593um
- SLE: 2+ NS OU

**STAAR TORIC™ IOL**

- Single piece, Silicone
- Pre-existing astigmatism
  - 2.0 D Toric IOL Neutralizes 1.5 D K cylinder
  - 3.5 D Toric IOL Neutralizes 2.25 D K cylinder

- Frosted plate haptics
- Large fenestrations
- Models
  - TF (10.8mm)
  - TL (11.2mm)

**AcrySoft® IQ Toric IOL**

- Design
  - Acrylic
  - Single piece
  - Posterior toricity
  - Toric axis markers

- Toric aspheric
  - Approved Feb. 2009

**Acrysof Toric IQ Axis Markers**
**Refraction vs. Diffraction**
- **Refraction**: An optic with a smooth, continuous surface that bends light rays, focusing them into a single image.
- **Diffraction**: An optic surface that contains physical steps, that divides light waves into wavelets that form the near and distant images on the retina.

**Crystalens**
- Crystalens Five-0
- Crystalens HD
- No UV protection
- Induces positive SA
- Dominant eye: plano
- Non-dominant eye: -0.50D
- Patient must understand that they will need reading glasses for near

**ReZoom™ IOL Product Specifications**
- Hydrophobic Vacuole Free acrylic material
- Balanced View Optics™ Technology
- Patented OptiEdge™ triple edge PC IOL design
- Three-piece design
- PMMA capsule fit haptics
- 6.0 mm optic, 13 mm overall length

**Diffraction**
- The spreading of light
- Occurs when light passes through discontinuities (i.e. steps or edges)
- In an optical system, light can be diffracted to form multiple focal points or images
- AMO Tecnis Multifocal
- AcrySol® ReSTOR®

**TECNIS® Multifocal Acrylic IOL Model ZMA00 Specifications**
- Full diffractive posterior surface
  - Pupil-independent
- Wavefront-designed aspheric anterior surface
- Light distribution 50/50
  - Not apodized
- Optical power add +4.0D

**Anatomy of the Apodized Diffractive Technology**
- Central 3.6 mm apodized diffractive structure
- Step heights decrease peripherally from 1.3 – 0.2 microns
- +4.0 add at lens plan equaling +3.2 at spectacle plan
- Anterior aspheric optic
- Outer refractive zone
Apodization

- Definition: A gradual modification in the optical properties of a lens from its center to its edge.
- Apodization is used in microscopy and astronomy to improve image quality.
- The ReSTOR apodized diffractive design controls both image quality and energy balance.

Physical Comparison

- Both +4.0 D and +3.0 D have 3.6 mm Apodized Diffractive region
- +4.0 D central zone diameter = 0.74 mm
- +3.0 D central zone diameter = 0.86 mm

True Performance at All Distances

AcrySof® IQ ReSTOR® +3.0 D IOL was specifically designed to:
- Maintain existing optical design characteristics and manufacturing processes
- Move near vision distance out 6-7 cm
- Improve intermediate vision without sacrificing distance and near¹

Source: AcrySof® IQ ReSTOR® IOL Package Insert.
Minimized Visual Disturbances at 6 Months

Exceptional Patient Satisfaction

Over 93% of IQ ReSTOR® +3.0 D IOL patients would have the same implant again

Spectacle Freedom

Overall Vision

Comparative S&E data

Future IOL Technology

- Akkommodative 1CU (Human Optics)
- Tetraflex IOL (Lenstec)
- Sarfarazi Elliptical IOL (B&L)
- Synchrony (Visiogen)
- FlexOptic Lens (Quest Vision Technologies)
- NuLens (NuLens)
- FluidVision IOL (PowerVision)
- LiquiLens (Vision Solutions)
- Smart IOL (Medenium)
- Light Adjustable Lens (Calhoun Vision)

What is your patient’s reaction when you give them the diagnosis of cataracts?

- Anxiety
- Uncertainty
- Confusion

Patient Education is the Key to Success
Risk Factors for Cataract Formation

- Genetic factors
- Sex
- UV radiation
- Smoking
- Alcohol consumption
- Diabetes
- Use of steroids
- Socioeconomic status
- Chronic dehydration, diarrhea, malnutrition

What Do Our Patients Know About Cataracts?

- What is a cataract?
- When do I need cataract surgery?
- How is the surgery done?
- Who do I go to?
- What are my options?
- Will I need glasses?
- Will I still see you after the surgery?

Education Starts with the Referring Optometrist

- Attend courses on ATIOLs
- OD’s role
  - Patient education
  - Identify patient visual needs / tasks
  - Recommendation
    - Need for surgery
    - IOL
    - Surgeon
  - Provide ATIOL information packet

Education is a Continuous Process

- Technician’s role
  - Astigmatism
  - Glasses Haters
- Cataract / ATIOL video
- Refractive Surgery Coordinator
  - Helps guide decision
  - Discusses financing options
- Doctor helps make the final determination

Advanced Technology IOL Discussion

- Example: Alcon Acrysof Restor
- Great distance, intermediate and near vision
- Near is at 16 inches with good light
- 5% glare/haloes at night
- 15% Need for Refinement
- Best vision is after surgery in both eyes

Cataract Evaluation
Case One

- CC: 77 YOWF, blurred VA OD>OS
- BCVA:
  - OD -5.50+1.25X015 20/50
  - OS -1.25+1.50X180 20/20

Which Comes First, The Chicken or the Egg?

- Glaucoma Evaluation First
  - Permanent loss of vision if not controlled
- Cataract Evaluation Second
  - Cataract surgery is an elective procedure and can wait

Case Example

- 65 YOWF Referred for Cataract Sx
  - Blurred VA X 6 months Dist / Near

IOL Choices in Glaucoma

"Yes – I would like to be free from glasses!"

STANDARD
TORIC
MULTIFOCAL

Stand-Alone vs. Combined Procedures

- Significance of the cataract
- Does the cornea need surgical intervention?
- Sequential versus triple procedure
- Convenience, cost, visual recovery
Preparation for Ocular Surgery

- Optimize the Ocular Surface
- Normalize the Lids
- Prepare the Cornea
- Eliminate Intra-ocular Inflammation
- Control Glaucoma
- Satisfy the Macula
- Evaluate the Retinal Periphery
- Patient Education

Pre-operative Testing

- Consider OCT imaging on all patients
- Conditions that may affect visual outcome
- Retina consult when in question

Scheduling Appointments

- Your office staff should schedule the appointment
- Clearly indicate that YOU are the referring doctor
  - Which office?
- Fax to Surgeon
  - Referral request form
  - Pertinent patient notes
  - Consent for co-management

Cataract Surgical Evaluation

- Who is the referring doctor?
- What is the doctor’s diagnosis and recommendation?
- Review doctor’s evaluation
- If cataract surgery is recommended, what IOL is recommended?
- Complete eye exam to confirm diagnosis and final recommendation
- Do you wish to comanage?

Optimizing Refractive Outcomes

- Accurate pre-operative refraction, keratometry & biometry
- Consistent surgical technique
- Ongoing evaluation of surgical outcomes
- Modification of clinical/surgical protocols based on outcomes

Preparing Patients for Lasik or PRK

- Up to 15% may need refinement:
  - Overcorrection
  - Undercorrection
  - Astigmatism
- Topography
- Pachymetry
- Are they a candidate?
Consider AK/LRI in Patients with Astigmatism

• Pros
  – Easy to learn
  – Less time
  – Correct at source
  – Predictable for low cylinder
  – Can’t rotate

• Cons
  – Longer incision / less predictable
  – More irritating
  – Can’t be used in keratoconus

Peri-Operative Management

Surgical Prophylaxis

• Antibiotics
  – One day prior to surgery
  – Fluoroquinolones - gatifloxacin, moxifloxacin, levofloxacin, besifloxacin

• NSAIDs
  – One day prior to surgery
  – In high risk patients, 1 week prior to surgery
  – Ketorolac, nepafenac, diclofenac, bromfenac

• 5% Povidone-Iodine

Cataract /Refractive Surgery Complications

• Operative Complications
  – Surgeon makes the call

• Post-operative Complications
  – Co-managing doctor makes the call

  Successful co-management is the result of continuous communication!!

Operative Complications

• Inadequate pupil size
  – IFIS

• Iris prolapse
  – Poor wound construction
  – Posterior vitreous pressure
  – Hyperopic eyes

• Zonular dehiscence
  – Trauma
  – Pseudoxefoliation

• Dropped nucleus

• Capsular tear

Operative Complications
Flomax (tamsulosin)
- Indication for the treatment of benign prostatic hyperplasia
- Alpha-1 blocker
- Intraoperative floppy iris syndrome
- Importance to communicate prior to cataract surgery

Post-operative Complications

Post-operative Day #1
- Confirm medications
- Uncorrected vision
  - Distance: reason for decreased vision?
    - Near: do not check
- IOP
- Slit lamp examination
  - Corneal wound secure?
  - Cornea clear? Edema?
  - AC well formed with about 2+ cell
  - IOL well centered in pupil

Patient Instructions
- Review medications
- No restrictions on physical activity
- Remind patient that it is normal for vision to be blurry and eyes out of balance
- Fax results to surgeon

Post-operative Pearls for Advanced Technology IOLs
- Remind patient that it is normal for vision to be blurry and eyes out of balance
- Avoid “buyer’s remorse”
- 5% of patients experience halos
- Bilateral implants
- Use -2.25D Glasses to reassure decision
- Communication with surgeon / referral center
- Check toric axis at one week

What are the Early Complications with Cataract Surgery?
Early Complications

- Cornea edema
- IOP spikes
- Wound complications
- Endophthalmitis
- IOL Surprises

Cornea Edema

- Temporary – endothelial shock
  - Prolonged phaco time
  - Dense nucleus
  - Endothelial health - >650 microns, Fuch's
- Appearance
  - Microcystic edema
  - Stromal folds and haze

IOP Spikes

- Retained viscoelastics
- Long standing glaucoma
- Treatment:
  - Topical glaucoma agents
  - Diamox
  - Osmoglyn
  - Open incision at the slit lamp

Decompression: Does it Really Work?

- IOP rise occurs 5 to 7 hours after surgery
- Causes ocular pain
- Causes sight – threatening complications
  - Retinal vascular occlusion
  - Progressive VF loss in advanced glaucoma
  - AION
- Controls IOP typically for 1 hour
- Additional treatment needed to protect vulnerable eyes


Wound Complications

- Potential for post-operative endophthalmitis
- Shallow A/C
- Low IOP
- Perform seidel test
- If A/C formed and no secondary complication from hypotony, treat conservatively
  - Bandage contact lens
  - Antibiotics – QID
  - Follow up q24h

Wound Complications

- Uveal incarceration
  - External pressure / eye rubbing
  - Iris prolapse
  - IOP normal
  - Look for leaks
  - Rigid shield on eye
  - Refer to surgeon
What are We Looking for at Week #1?

Post-operative Week #1

- Confirm medications
- Uncorrected vision
  - Distance: Refraction (reason for decreased vision?)
  - Near with good lighting
- IOP
- Slit lamp examination

Post-operative Week #1

- Patient instructions:
  - Review medications
  - Review instructions for next surgery
  - Complete QOL questionnaire for 2nd eye
- Encourage patient
  - Avoid “buyer’s remorse”
  - Premium IOLs – Bilateral / Haloes / -2.50D Glasses
- FAX results to surgeon

Endophthalmitis

- 3-5 days after surgery
- 4+ cell and hypopyon
- Pain
- Eyelid edema
- Decreased vision
- If patient calls with symptoms during the first week: the doctor must see the patient
  - Surgical emergency: hours (not days) make a difference

IOL Surprises

- Greater than 1D from planned refractive result
- Poor measurements - Axial length, Keratometry, A-constant, Software program
- Mistake in the OR
- Wrong packaging
- Must identify problem within the first week*
- Treatment
  - IOL exchange

Dislocated IOL

- Consider in High Risk Patients
  - Pseudoxefoliation
  - Marfans
  - Trauma
- Unrecognized zonular dehiscence
- Unrecognized tear in posterior capsule
- Treatment
  - Repositioning or IOL exchange
Month #1 Considerations

Post-operative Month #1

- Uncorrected vision
  - Distance
  - Near with good lighting

- Final refraction
  - Visually significant cylinder?
  - Overcorrection?
  - Undercorrection?

- IOP

Post-operative Month #1

- Slit lamp exam:
  - Cornea: clear? edema?
  - Look for surface disease: dry eye? SPK?
  - AC well formed with no cell
  - IOL well centered in pupil
  - Evaluate posterior capsule

- Fundus exam
  - Confirm that there is no CME
  - Peripheral retina

- Patient recommendations:
  - Post-operative spectacles?
  - Treat surface disease?
  - Yag capsulotomy?
  - Laser vision correction?

- It may take several more months to obtain your very best vision

  Fax results to surgeon

Later Post-operative Complications

- Ocular surface disease
- Posterior capsular opacification
- Cystoid macula edema
- Rebound inflammation
- Retinal detachment
- IOL surprises
- Dislocated IOLs

Pearl – All visual fluctuation is due to ocular surface disease
Posterior Capsule Fibrosis

- Proliferation of equatorial lens epithelium along post capsule
- Incidence 10-25%
- Treatment - YLC
  - Complications – Iritis / IOP spikes / RD / CME

Cystoid Macular Edema

- CME is the most frequent cause of visual decline following uncomplicated cataract surgery
- Late on-set (4 to 6 weeks post-operatively)
- Estimated to occur in 12% of low-risk cataract cases
- CME development is due in part to prostaglandin-mediated breach of blood-retinal barrier


Multifocal Pearls

- Treat residual refractive errors
- Early yag capsulotomy
- Aggressively treat ocular surface disease
- Look for cystoid macular edema (CME)

My Experience with ATIOLS

- 99% 20/Happy patients
- Most problematic patients have ocular surface disease
  - "I never had dry eye before"
  - Importance of Dx/Tx pre-operatively

Future Considerations

- Femtosecond technology
- Sophisticated implantation methods
- Intraoperative measurement
- Emerging IOL technology
- Iris fingerprinting

Femtosecond Lasers in Ophthalmology

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

A dynamic platform technology that will:
• Deliver true refractive cataract surgery with the precision of a femtosecond laser
• Establish Laser Refractive Cataract Surgery — a viable new advanced technology category
• Rapidly advance the evolution of true image-guided intraocular surgery
• Advance the development of a more digitized, predictable approach to lens replacement surgery

LenSx® Laser Integrated OCT

Image-guided Laser Refractive Cataract Surgery
• Intuitive touch screen Graphic User Interface - for easy customization of all surgical parameters
• Real-time video imaging for 3D visualization - guides the surgeon while docking - for optimal surgeon control
• True image-guided surgical planning - enables the surgeon to precisely program size, shape, location of each incision

Traditional Cataract Surgery: Common Complications
• 10-40% Posterior capsule opacification
• 2-12% Transient cystoid macular edema
• 1-5% Vitreous prolapse or loss
• 4-10% Corneal endothelial cell loss

Traditional Cataract Surgery: Vision Threatening Complications
• 0.6-2% Retinal detachment
• 1-2% Persistent cystoid macular edema
• 0.3% IOL Malposition
• 0.3% Consecutive corneal transplantation
• 0.1% Endophthalmitis

Quality = Safety
• Fewer Wound Leaks: Multiplanar Incisions
• Lower Endophthalmitis Rates
• Fewer Corneal Abrasions, Less PO Pain
• More Predictable PO Astigmatism
• LRIs arcuate & without induced Dry Eye
• Less IOL Decentration & IOL Tilt
• Fewer YAG Capsulotomies
• Less Phaco Time
• Fewer Ruptured Posterior Capsules
• Lower Endothelial Cell Loss

Femtosecond Cataract Surgery: FDA Approved
• LenSx: Capsulotomy, Incision, Fragmentation
• LensAR: Fragmentation, Capsulotomy
• Optimedica: pending
• Technolas: pending
• Nidek: pending
LenSx® Laser Arcuate Incisions

Image-guided surgical planning with 3D visualization
- Real time corneal thickness
- Computer programmed incisions
  - % depth
  - incision length and position
  - 3D visualization of incision placement
- Predictable incision width, tunnel length
- Titratable incisions
  - adjustable during surgical procedure
  - adjustable post-op at slit lamp

Microincision Cataract Surgery

- Why?
  - Quicker recovery
  - Better wound strength
  - Lower complication rates
  - Better outcomes
- Emergence to sub-2.0mm incision
- B &L Stellaris - 1.8mm
- Alcon Infiniti – 2.2mm

Laser Refractive Cataract Surgery

ORange™ Technology

- Intraoperative wavefront aberrometer
- Talbot-Moire’ interferometry
- Improved outcomes w/ LRIs
- Toric lens positioning
- Reduce LASIK enhancements

AT LISA (Carl Zeiss Meditec)

- Light distributed asymmetrically
- Independence from pupil size
- SMP technology
- Aberration correcting aspheric optic
- Fits through 1.5mm incision
- Aspheric toric anterior surface
- Aspheric multifocal posterior surface
- +3.75 Add at IOL plane

Rayner Premium IOLs

- Rayner T-flex®
  - Spheres: +6.0D to +30.0D in 0.5D increments
  - Cylinders: +1.0D to +6.0D in 1.0D increments
- Rayner M-flex® T
  - Refractive, aspheric optics
  - Spherical equivalent: +14.0D to +32.0D in 0.5D increments
  - Cylinder: 2.0D
  - Addition: +3.0D or +4.0D
- Sulcoflex Toric
  - Supplementary IOL
  - Post-surgical / residual ametropia
**Comanagement Pearls**

- Identify potential causes of surgical complications
- Educate your patients your role within medical eye care
- *We are all judged by the visual outcomes our patients. Comfort and quality of vision is the key!*  

**Make this an *exciting* opportunity for your patients**

- This is a great time to have cataract surgery as we can offer you so much more than several years ago
- This is your one opportunity to select your intraocular lens
- We will give you the information you need and help you make this important decision

**Thank You !!!!**

*Virginia Eye Consultants*

*Research*

*Education*

*Clinical Excellence*

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