

NEWSLETTER

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Spring 23



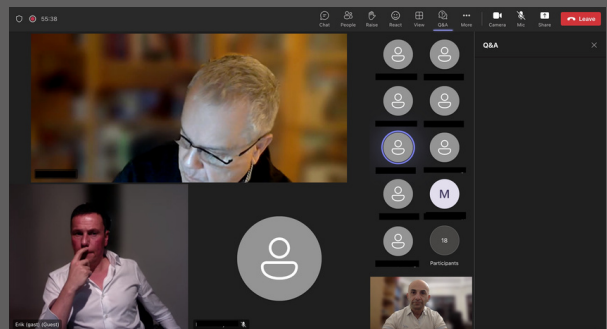
Spring Forward

It has been a very busy couple of months since the January newsletter and I hope to share some of the highlights with you.

The annual appraisal is a compulsory undertaking for all doctors in the UK. It is comprised of several aspects (or domains) and leads to revalidation with the GMC every five years. Part of the appraisal is concerned with surgical outcomes benchmarked against National data. I was very pleased to report that my personal posterior capsule rupture rate for the previous 12 months was 0% (zero).

My teaching program for SE Wales trainees included fact-checking of the EIDO information leaflets for cataract surgery and for YAG laser posterior capsulotomy. These leaflets are given to patients at the initial consultation and are generally representative of the published literature, but with some small variations. We also presented a summary of a very helpful recent published paper that summarised the best-practice approach to Vernal Keratoconjunctivitis; and a lecture on how to select cataract patients for toric lens implants, how to calculate for the toric lens power and implantation considerations.

I was delighted to be a co-presenter in a live webinar on the use of the Vivinex trifocal lens implant from HOYA Surgical Optics. The webinar was arranged for a select group of surgeons in the UK to hear about the experience of two surgeons that had been given access to this lens over the last couple of years. Those surgeons being myself and Dr Eric Mertens of Belgium. Eric and I shared our experience of using the lens intra-operatively as well as the objective and subjective results. I presented my results using the CLEARlog software and app that I have recently developed and which I use to capture all my private surgical activity. I have previously presented my results at American, European and UK & Ireland cataract congresses and was able to share these with UK colleagues on this webinar. Oh, just to say, the objective and subjective results are very satisfactory.



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QUIZ

The answer to the Quiz Question in January's newsletter.

The two ways of providing glasses-free vision after cataract surgery (other than using a multifocal lens implant) are:

1. Monovision using a Monofocal IOL in each eye and targeting approximately -2.5 D of myopia in the non-dominant eye.
2. Mini-monovision using an Enhanced Monofocal / Increased Range of Focus (IRoF) lens in the non-dominant eye and targeting -0.75 D to -1.0 D of myopia and so causing less anisometropia and reduced degradation of stereopsis. This is a very useful option for patients that are highly motivated to optimise unaided near vision but are unsuitable for multifocal lens implants.

Name 3 common causes of irregular astigmatism that may be present in cataract patients (and present similar challenges to this case)

Answer in the next newsletter.



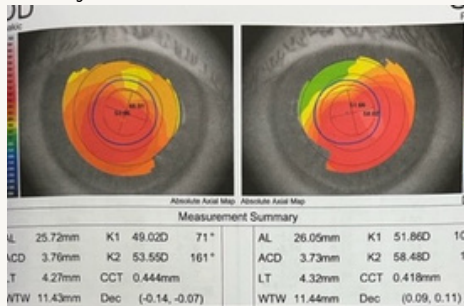
A 72-year-old lady with long-standing keratoconus developed cataract and was referred by her optometrist. She wore RGP contact lenses with good effect but noticed a decline in vision that I confirmed was due to cataract.

At presentation the VA and refraction were:

RE UVA Count Fingers; -8.0 / -3.5 x 7 deg
BCVA 6/19

LE UVA Count Fingers; -9.0 / -5.75 x 105 deg
BCVA 6/24

Aladdin topography showed advanced keratoconus, and biometry calculations showed a need for lower dioptric power lenses with high astigmatic correction for each eye.



So, what are the banana skins and approaches to optimise the outcome?
Banana skins:

- To use a toric lens, or not to use a toric lens? That is the question.
- To avoid making it difficult for the optometrist to provide a refractive correction post-operatively, with either glasses or a contact lens.
- Manage patient expectations appropriately.

Approaches to optimise outcomes:

- Spend plenty of time pre-operatively counselling and providing information.
- Answer all questions openly and honestly.
- Offer further discussions by phone or at a further consultation. In fact, this lady had two consultations before surgery.

- Take all relevant investigations pre-operatively, including topography.
- Use topography-assisted biometry and most appropriate formula for lens calculations.
- Explain the options that can most closely provide the desired outcome.

What I did specifically, in addition to the above:

- Provided written information in a booklet that I wrote myself and give to all patients.
- Emphasised the issues that are relevant in the context of keratoconus, especially reduced biometry accuracy, and that residual refractive error and astigmatism are almost certain.
- Took multiple biometry measurements using the Topcon Aladdin (which includes topography)
- Spoke with the referring optometrist to establish that the patient had previously enjoyed acceptable vision with glasses. This is important because using a toric lens in the presence of irregular astigmatism is only beneficial if the patient has gained reasonable vision with glasses. If that is not the case, then it is best to use a non-toric lens and rely fully on contact lens correction for visual rehabilitation post-operatively.
- Spoke with the referring optometrist to discuss my plan and ensure that he would be happy to perform a refraction and fit glasses and/or contact lenses if I used a toric lens.
- Performed micro-incision surgery using a 2.2mm incision, direct chop technique and insertion of a monofocal toric lens implant into the capsular bag.
- Close communication with the patient's optometrist and post-operative review of the patient in my clinic. The patient was delighted with the result of surgery in each eye.
- Finally, I enjoyed the final post-operative refraction and report from the optometrist:
 - o RE UVA 6/15 +1.25 / -2.75 x 55 deg 6/9.5
 - o LE UVA 6/15 +0.25 / -2.25 x 18 deg 6/9.5

