Please stay tuned….
Currently taking a break!

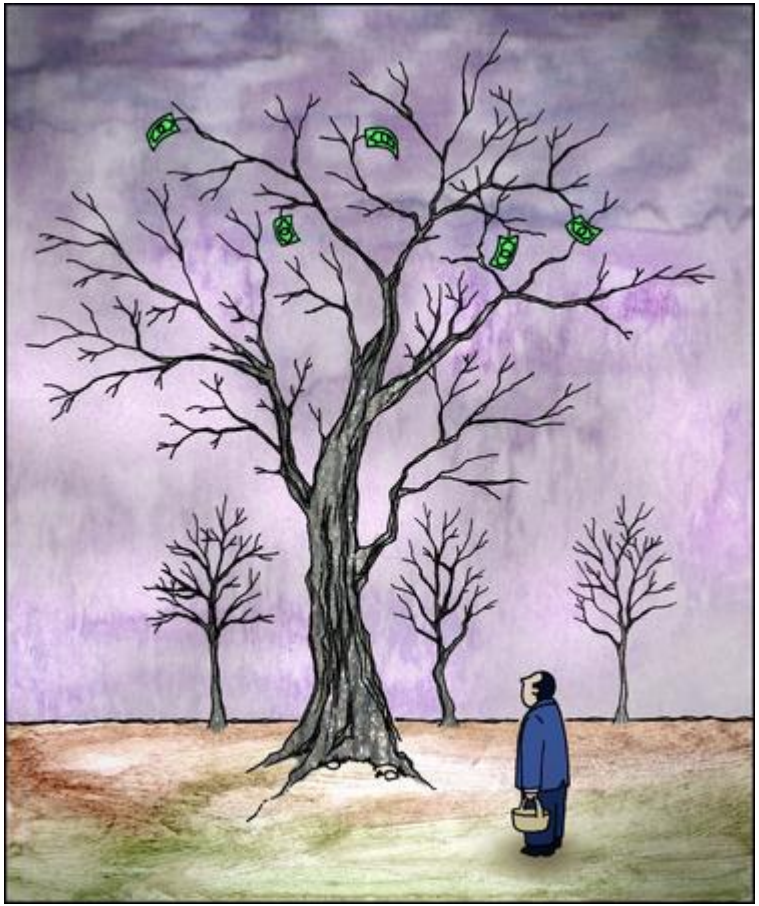
Co-management from your office, to our's, and back

Christopher Carver, OD
Paul Phillips, MD
Sightline Ophthalmic Associates

Financial Disclosure

My Money Tree

None



Summary of Presentation

- Pre-op
  - Importance of referral information
  - How the referral is used along with our exam
  - Testing and discussion in our office
    - Surgery
    - Lens options
    - Risk discussion

Summary of Presentation

- Surgery
  - Discussion and Videos
- Post-op
  - What to look for and when
  - When to refer patient back to surgeon
  - Need for communication of your post op to the surgeon
    - We hired new staff member to obtain our post ops

P
A

Co-management

- Definition
  - Co-management is defined as the relationship between an ophthalmologist/cataract surgeon and a non-operating provider (an optometrist) for shared responsibility in the postoperative care.

Co-management

- Communication
  - There has to be a specific paper trail between the optometrist and the ophthalmologist. These forms include:
    - Initial referral form from OD to OMD
    - Patient election for co-management form
    - Transfer of care form
    - Post-operative assessment sheet.
      - We are requesting our forms for pre and post op
      - New staff member to retrieve post op forms

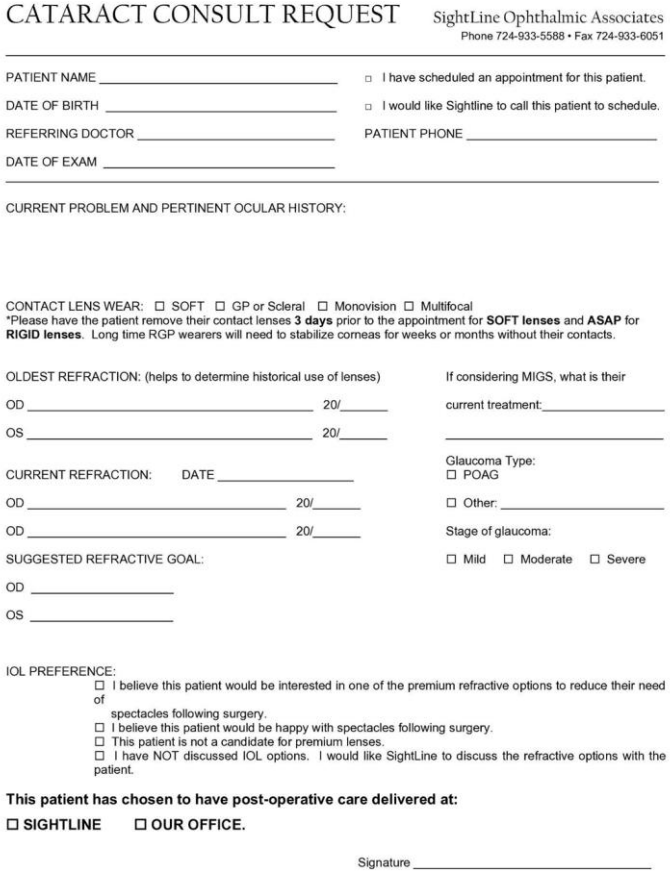
Post operative care

- Covers care related to the surgery for 90 days after the surgery.
- Optometrist takes over responsibility of care when the patient is released/transferred from the surgeon's office.
  - In most cases, we release patient after their 1-day post op visit in our office.
  - If patient needs seen prior to 1 week visit, we will contact your office to get the patient scheduled sooner. Flexibility with your schedule is required.
  - Covers all visits related to the surgery (unable to bill the patient for care related to surgery)
- Co-managing office needs to be available to the patient.
  - Requires possible communication or care after hours. ie. Someone on call
  - Asking a patient to report to the closest ER is not co-management.
    - The ER may be the last place for our patients.
- Referral back to surgeon if any complications observed
  - Paul will expand on this in his presentation.

Initial Referral Form

Sightlinelaser.com

- For Referring Docs
- Forms



CATARACT CONSULT REQUEST

SightLine Ophthalmic Associates
Phone 724-933-5588 • Fax 724-933-6051

PATIENT NAME _____ ☐ I have scheduled an appointment for this patient.

DATE OF BIRTH _____ ☐ I would like Sightline to call this patient to schedule.

REFERRING DOCTOR _____ PATIENT PHONE _____

DATE OF EXAM _____

CURRENT PROBLEM AND PERTINENT OCULAR HISTORY:

CONTACT LENS WEAR: ☐ SOFT ☐ GP or Scleral ☐ Monovision ☐ Multifocal
*Please have the patient remove their contact lenses **3 days** prior to the appointment for **SOFT lenses** and **ASAP** for **RIGID lenses**. Long time RGP wearers will need to stabilize corneas for weeks or months without their contacts.

OLDEST REFRACTION: (helps to determine historical use of lenses)

OD _____ 20/_____

OS _____ 20/_____

CURRENT REFRACTION: DATE _____

OD _____ 20/_____

OD _____ 20/_____

SUGGESTED REFRACTIVE GOAL:

OD _____

OS _____

If considering MIGS, what is their current treatment:_____

_____

Glaucoma Type:
☐ POAG
☐ Other: _____

Stage of glaucoma:
☐ Mild ☐ Moderate ☐ Severe

IOL PREFERENCE:
☐ I believe this patient would be interested in one of the premium refractive options to reduce their need of spectacles following surgery.
☐ I believe this patient would be happy with spectacles following surgery.
☐ This patient is not a candidate for premium lenses.
☐ I have NOT discussed IOL options. I would like SightLine to discuss the refractive options with the patient.

This patient has chosen to have post-operative care delivered at:

☐ SIGHTLINE ☐ OUR OFFICE.

Signature _____

Initial Referral

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Initial Referral

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Initial Referral

- Please look for the conditions listed!
- If you are noting a problem on the referral, please communicate the condition with the patient!!
- We are obligated to discuss these conditions with patient since they can affect their surgery. We will be as diplomatic as possible but if you have not discussed them, perception is that you missed them!

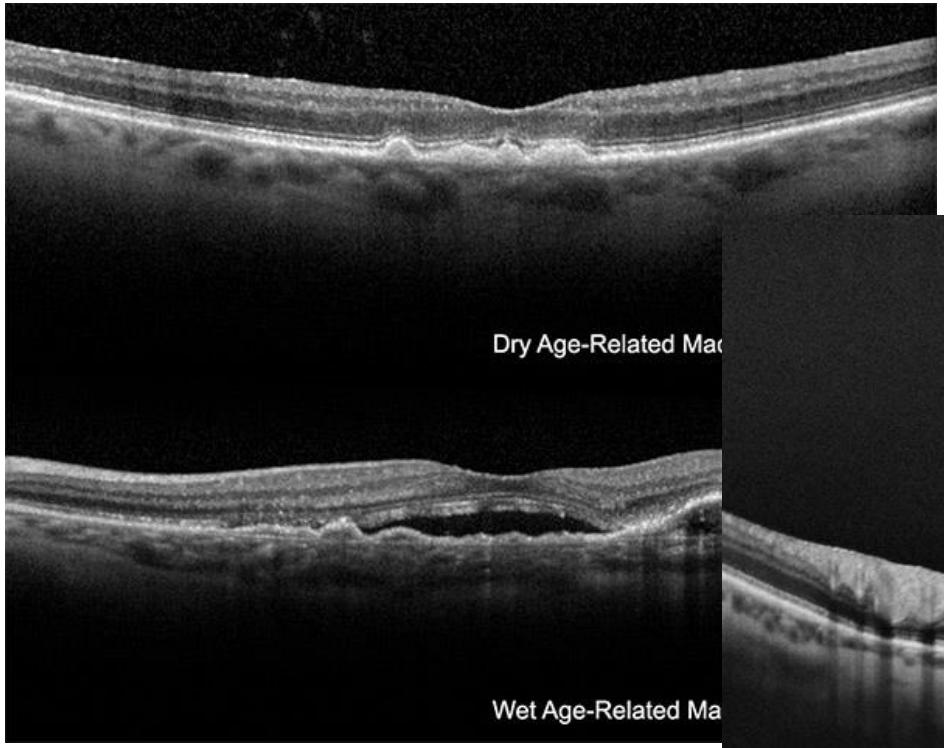
Initial Referral

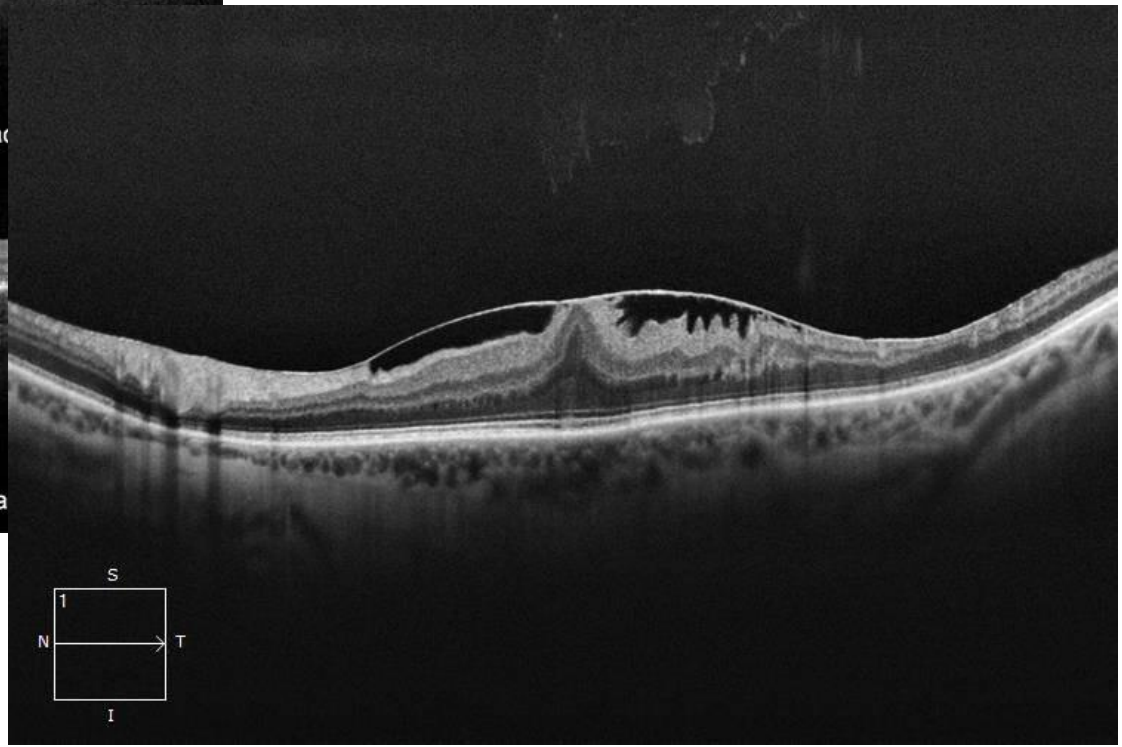
Current Problem

- Note grade of cataract in each eye
  - Does the grade of cataract correlate with VA?
    - Same level cataract + different va’s = something else!

74 WF referred for cataract evaluation

- Good general health
- Incoming report
  - BCVA: OD: 20/40 OS: 20/200
  - OU: gr 2+ NS with cortical spoking
- Exam in our office
  - BCVA: OD: 20/50 OS: 20/400 PHNI OU
  - OU: Gr 3 NS with cortical spoking
  - Fundus exam: normal ONH OU, drusen OU with possible sub macular fluid OS


Dry Age-Related Mac
Wet Age-Related Ma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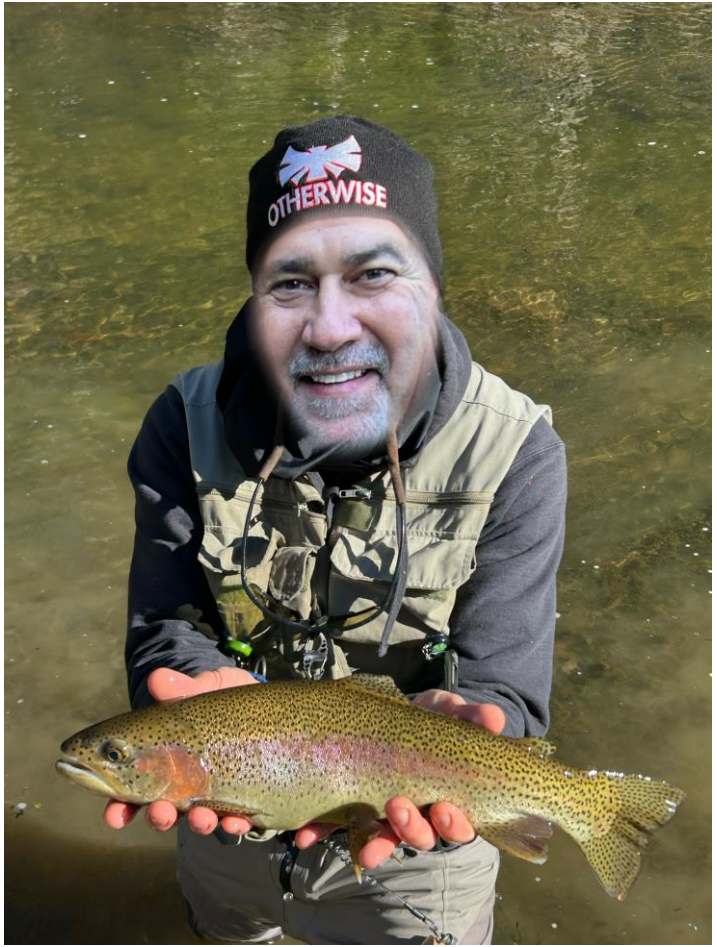
Nice rainbow trout!!



Initial Referral

Current Problem

- Note grade of cataract in each eye
  - Does the grade of cataract correlate with VA?
    - Same level cataract + different va's = something else!
- Note vision problem – need symptoms to proceed
  - Blur
  - Glare
  - Myopic shift

Initial Referral

Pertinent Ocular History

- Previous ocular surgery
  - Refractive Surgery (Lasik/PRK)
    - Complicates IOL power calculation
      - New equipment and formulas take into account total corneal power = better outcomes
    - Tend to have high expectations
    - Not the best MFIOL candidates

Initial Referral

Pertinent Ocular History

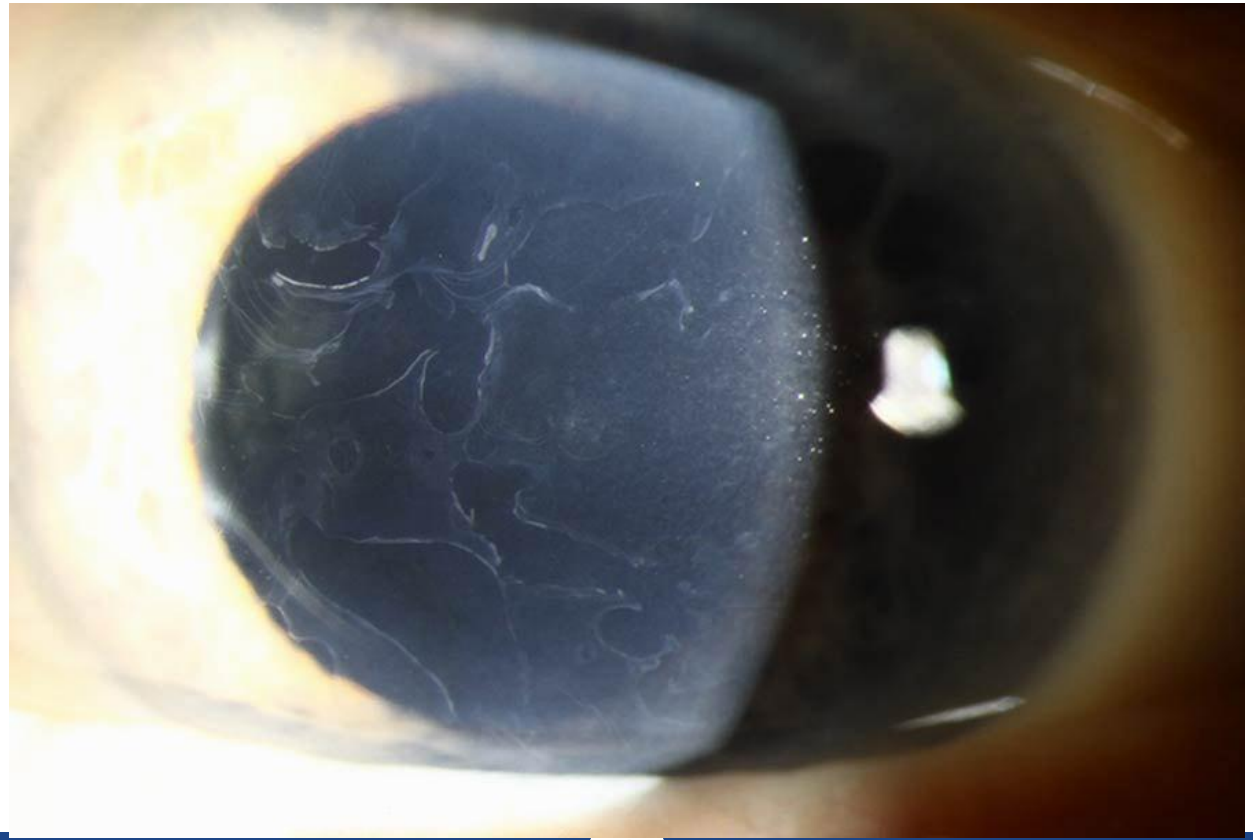
- Previous ocular surgery
  - Retinal surgery
    - RD with laser or buckle
    - ERM peels
    - Not good MFIOL candidates
- Trauma
  - Can cause zonular damage
    - We order backup lenses (3 piece and ACIOL)

Initial Referral

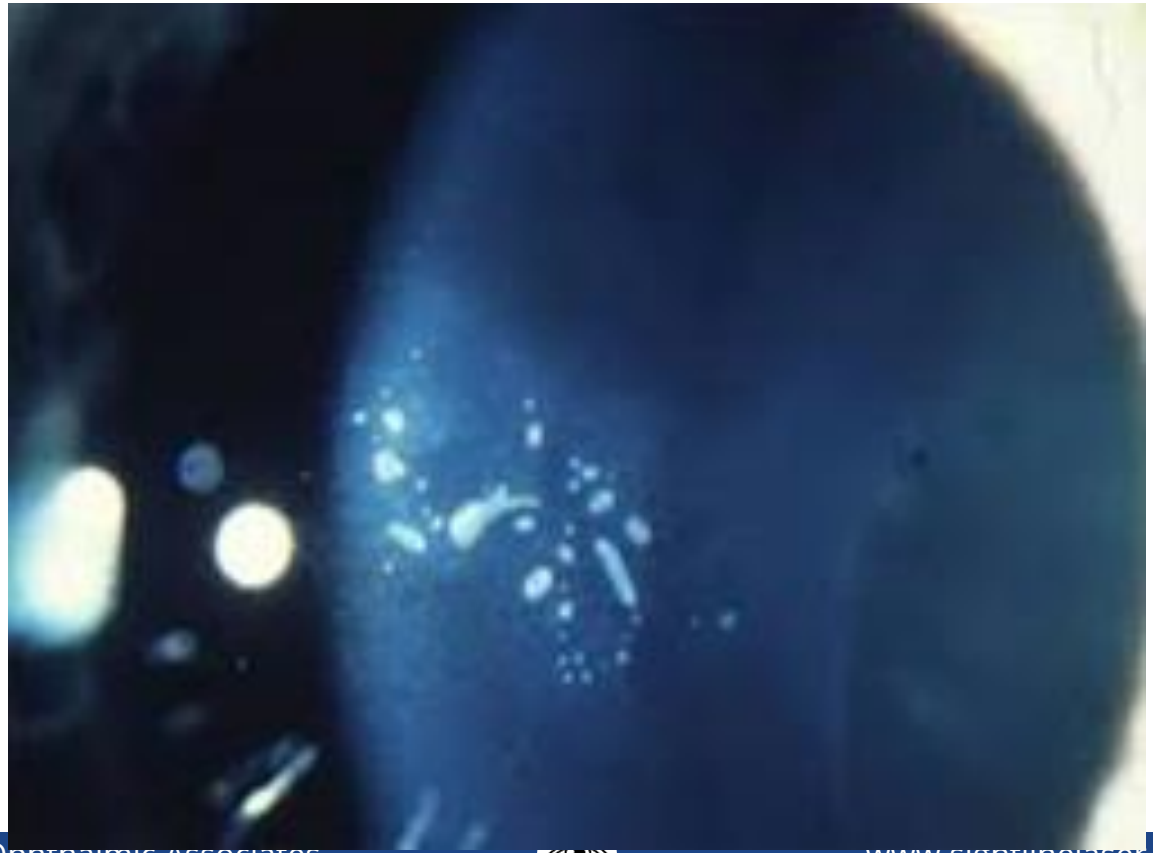
Pertinent Ocular History

- Ocular surface problems affect K readings
  - Dry eyes
    - Have patient start treatment prior to cat eval
  - EBMD/Nodules/Pterygium
  - May require procedure prior to cataract surgery to get accurate measurements
  - Ocular herpetic history
  - Not the best MFIOL unless cleared prior to measurements.

Map Dot Fingerprint Dystrophy



Map Dot Fingerprint Dystrophy



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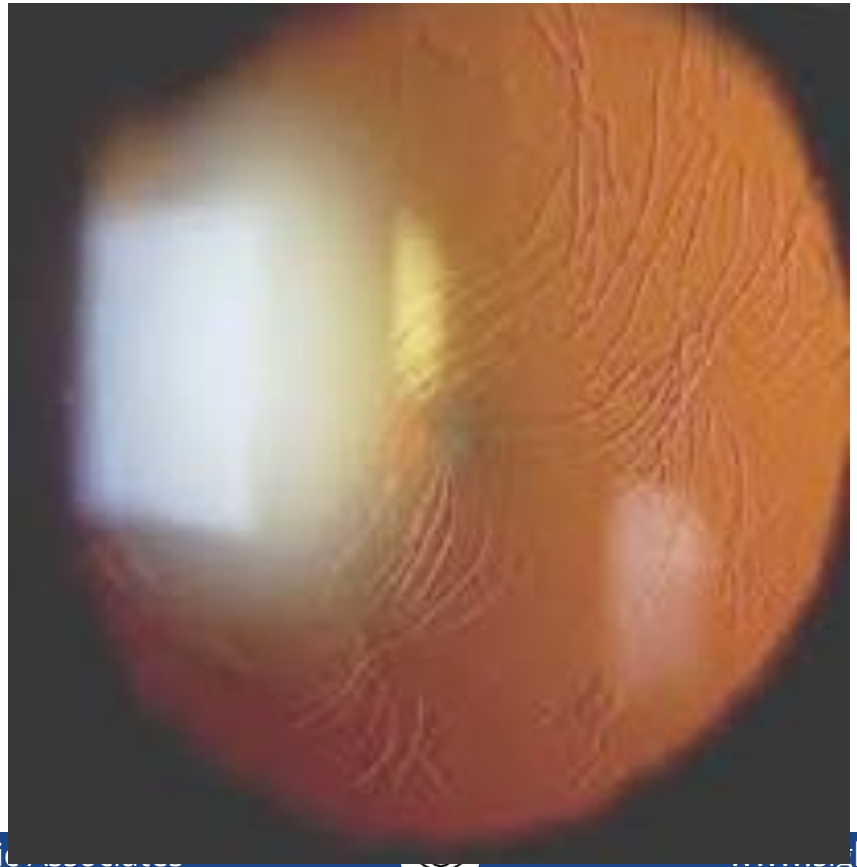
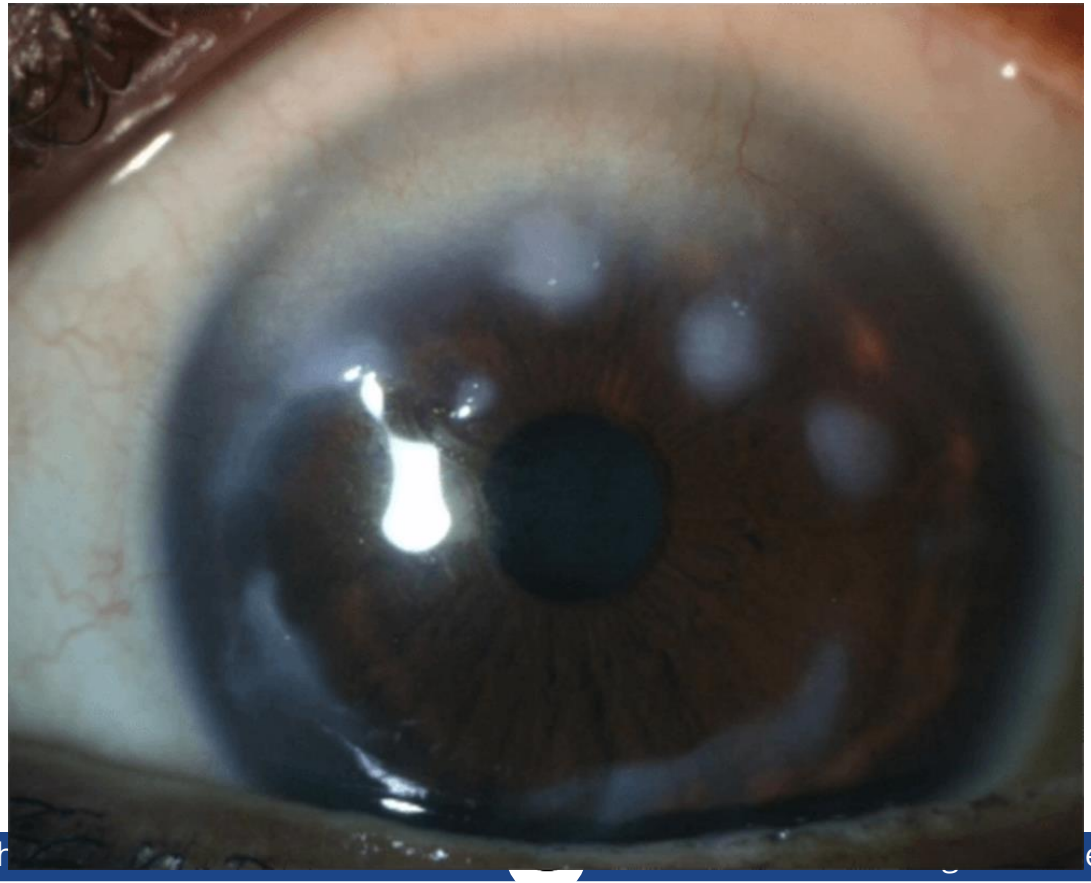
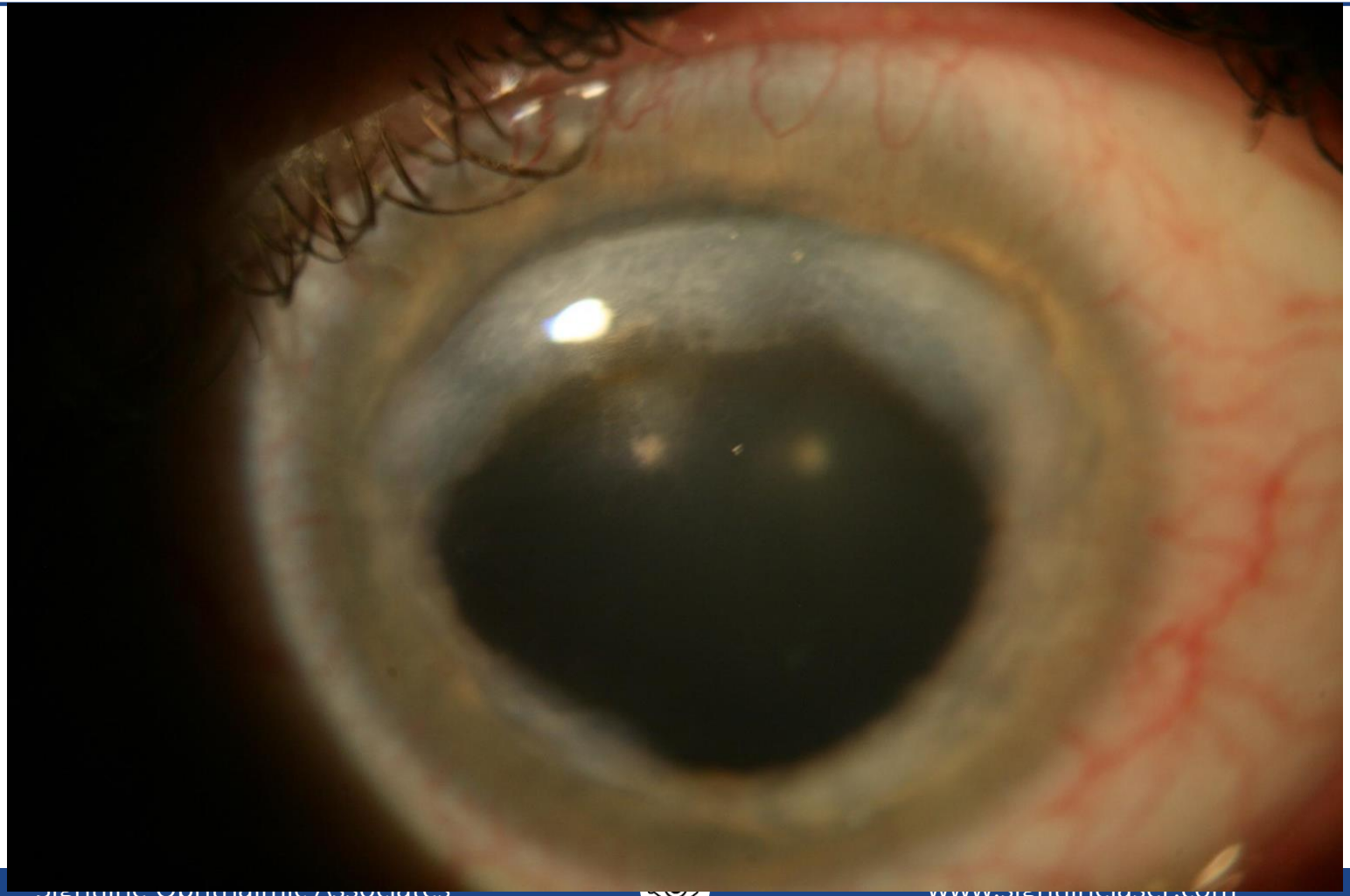
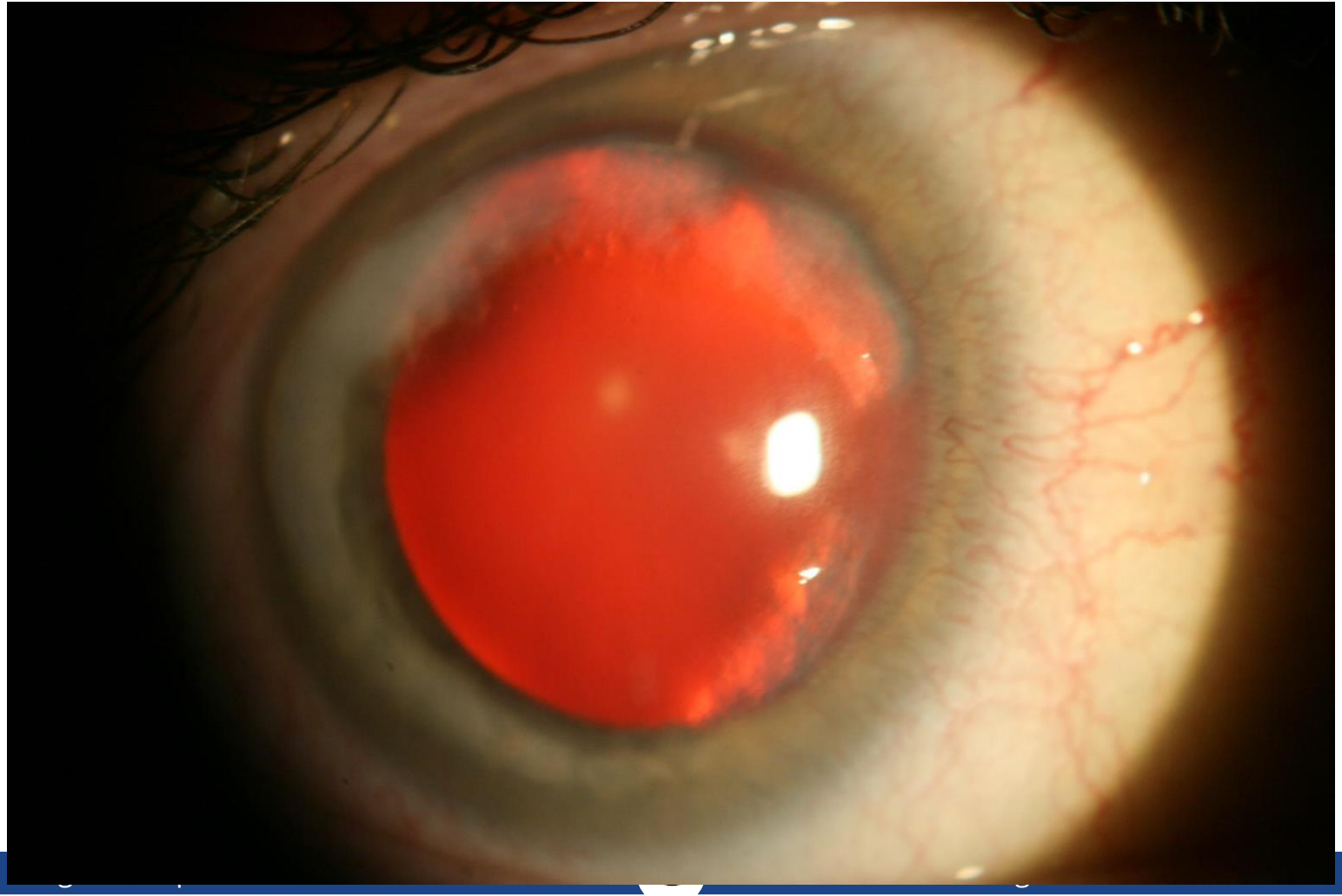


Salzmann’s Nodular Degeneration



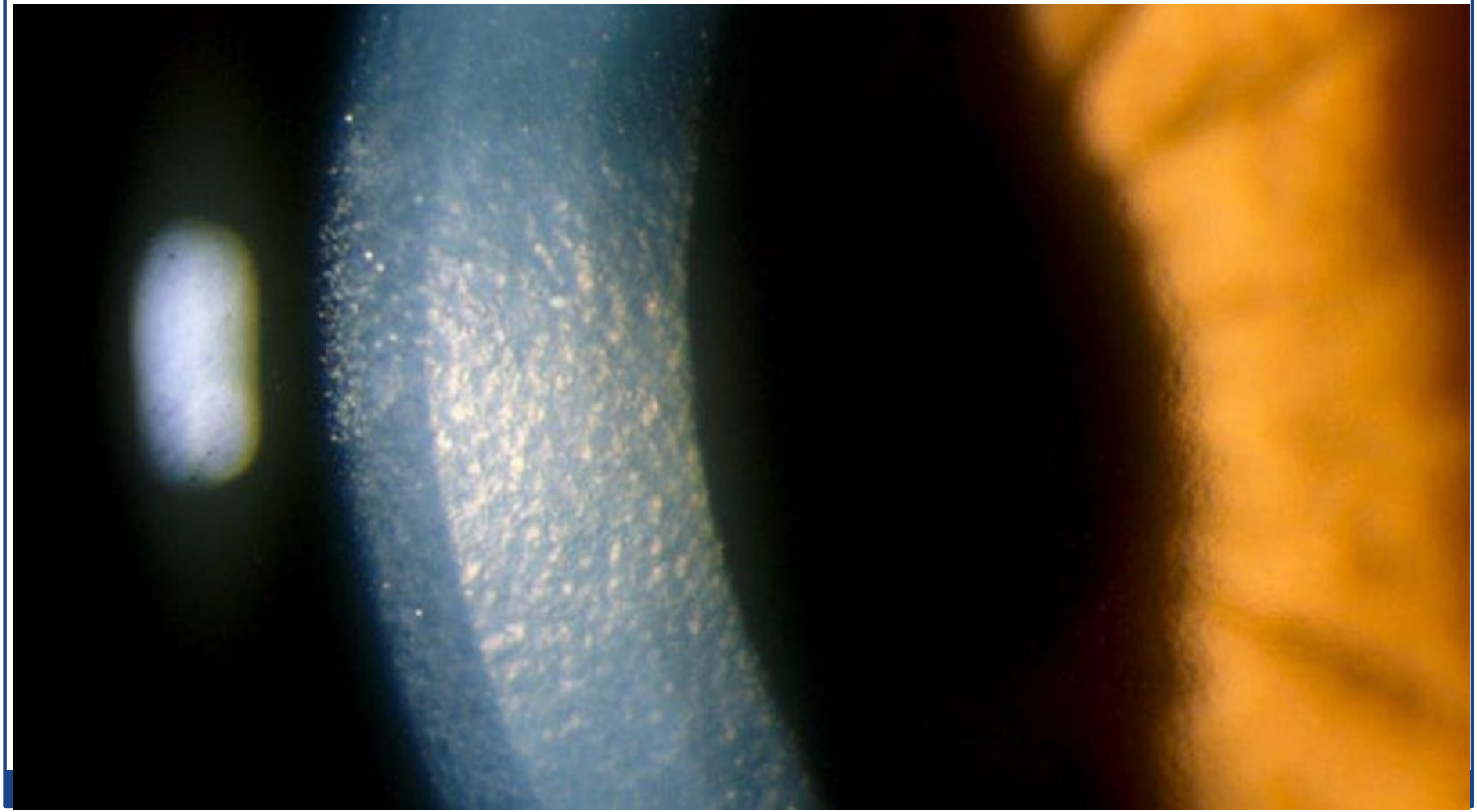




Initial Referral

Pertinent Ocular History

- Posterior Corneal Changes
  - Fuchs Dystrophy
    - May require surgery combined with EK
    - Need to understand likelihood of edema
    - Contrast sensitivity will be limited
      - Not a good MFIOL candidate



Initial Referral

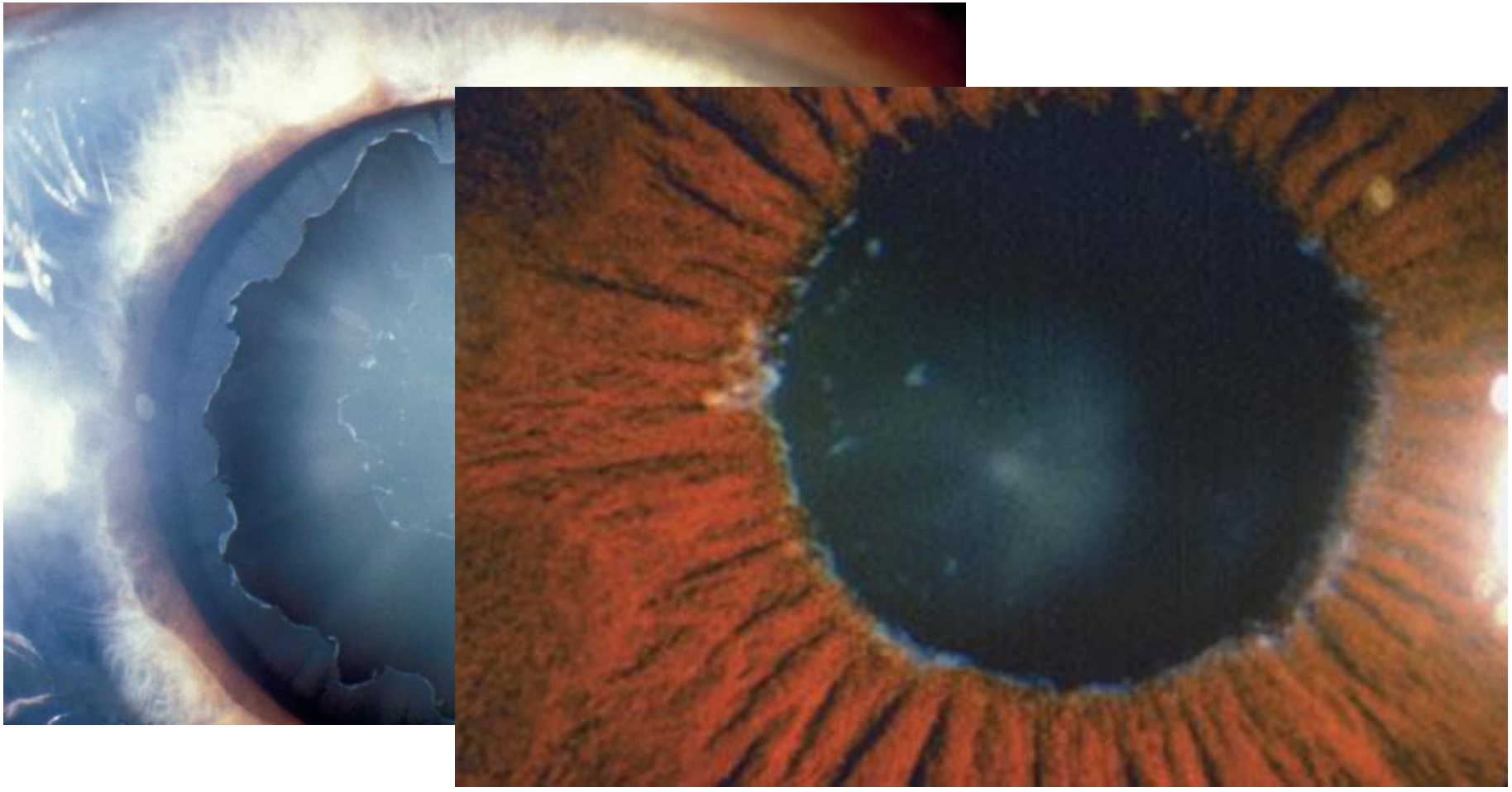
Pertinent Ocular History

- Posterior Corneal Changes
  - Keratoconus/Pellucid Marginal Degeneration
    - Needs to be stable - cxl if not
    - Can consider toric IOL if not planning to use RGP/Scleral contacts after surgery.
    - Not good MFIOL candidate

Initial Referral

Pertinent Ocular History

- History of Uveitis
- Pseudoexfoliation
  - More complicated surgery with possible zonular loss
  - May require capsular tension ring
  - We calculate for 3 piece and anterior chamber IOL
  - Not the best MFIOL candidate, can make Toric IOL placement difficult



Initial Referral

Pertinent Ocular History

- Macular pathology
  - ARMD - dry, wet or geographic
  - ERM
  - Diabetic retinopathy/Macular edema
  - Anything affecting macular physiology
  - We may get a retinal consult prior to cat surgery
  - Needs discussion on expected outcomes
  - Poor MFIOL candidates

Initial Referral

Pertinent Ocular History

- Vascular or Neurologic conditions
  - Artery occlusions
  - Vein occlusions
  - Ischemic optic neuropathies
  - Any brain abnormalities affecting vision or visual pathway.
  - Need to discuss visual potential prior to surgery.
  - Poor MFIOL candidates

Then who is a good MFIOL candidate?

- Personality – non perfectionist
- Habitual Rx – hyperope…good...low myope...not good
- Healthy anterior and posterior segment
- Desire to be limit need for correction
- Financially able to afford.
- Realistic expectations
- I always use the term limit Rx vs eliminate. I always tell patients there may be tasks where they will still need correction.

Initial Referral

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OLDEST REFRACTION: (helps to determine historical use of lenses)

OD _____ 20/_____

OS _____ 20/_____

CURRENT REFRACTION: DATE _____

OD _____ 20/_____

OD _____ 20/_____

SUGGESTED REFRACTIVE GOAL:

If considering MIGS, what is their

current treatment:_____

_____

Glaucoma Type:
☐ POAG

☐ Other: _____

Stage of glaucoma:

☐ Mild ☐ Moderate ☐ Severe

Initial Referral

Contact Lens History

- For best keratometry readings, patient needs to be out of contacts for a period of time!
  - Patients annoyed when not notified
    - Our welcome packet mentions it if they read it!
- Gives us an idea of what the patient has adapted to.
- Assists in our IOL and target discussion.
- Please note, patients wearing RGP’s may need to be out of them for months if they desire premium IOL!

Initial Referral

Oldest and Current Refraction

- Helps us understand what patient has adapted to regarding their refraction.
  - Always emmetropic
  - Always myopic or hyperopic
  - Myopic shifts - does patient like it or not??
  - Does the patient remove rx when reading??
- All patients should be refracted prior to referral for surgery.

Initial Referral

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SUGGESTED REFRACTIVE GOAL:

If considering MIGS, what is their

current treatment:_____

_____

Glaucoma Type:
☐ POAG

☐ Other: _____

Stage of glaucoma:

☐ Mild ☐ Moderate ☐ Severe

Initial Referral

Glaucoma patients who may benefit from MIGS.

- Type of Glaucoma
  - Hydrus and iStent - only mild or moderate POAG
  - Canaloplasty and Goniotomy - include other types
- Current treatment – Drops or previous SLT treatment
- Stage of Glaucoma – Mild, Moderate, Severe

- Consider referring severe glaucoma to specialist.

Initial Referral

SUGGESTED REFRACTIVE GOAL: ☐ Mild ☐ Moderate ☐ Severe

OD _____

OS _____

IOL PREFERENCE:

☐ I believe this patient would be interested in one of the premium refractive options to reduce their need of spectacles following surgery.

☐ I believe this patient would be happy with spectacles following surgery.

☐ This patient is not a candidate for premium lenses.

☐ I have NOT discussed IOL options. I would like SightLine to discuss the refractive options with the patient.

This patient has chosen to have post-operative care delivered at:

☐ SIGHTLINE ☐ OUR OFFICE.

Signature _____

Initial Referral

Suggested Refractive Goal/IOL Preference

- Helps us determine type of implant and target for patient.
- Allows you to help guide the outcome if you have a feeling how the patient should proceed.
- PLEASE give input if you feel a patient would be a good or bad specialty lens candidate!!
- If suggesting monovision, please let us know distance/near eye and how myopic to leave near eye.

Beautiful, large brown trout I caught!

Initial Referral

Patient has chosen to have their post operative care delivered at:

Sightline vs Your Office

Optometrist should have communication with the patient that there is an option for their post operative care to be done in their office.

Pre-op Evaluation

We review:

- History
- Questionnaire
- Discusses IOL options
- Questions on how vision affecting ADL
- Incoming Report
- Biometry
- Keratometry – IOLmaster, Topography, manual
- Full dilated exam

Biometry and IOL Calculation

We use IOL masters

- Measure: Axial length, anterior chamber depth, lens thickness, CCT, anterior and total corneal power, white to white

We use multiple formulas to calculate IOL power

- Defaulting to Barrett Universal II Formula

IOL’s available in 0.50 diopter increments

- Sphere and toric

Lens Discussion

- MFIOL
- Prefer Panoptix Trifocal IOL
- Requires clear anterior and posterior segment
- Can correct up to 3 diopters of astigmatism
- Warn about rings at night
- In perfectionists – warn about loss of contrast
- Can use Vivity EDOF lens if not ideal candidate
- No rings in lens
- Near VA not as good – J5 (20/50)

Lens Discussion

- Astigmatism correction
- Toric IOL
- >0.75 D of ATR
- >1.25 D of WTR
- Can correct up to 5 diopters at corneal plane
- LRI
- >0.50 D and <0.75 D ATR
- >0.75 D and <1.25 D WTR
- If discussing need for astigmatism correction with patient, please refer to corneal cylinder and NOT refractive!!
- My doctor told me I will just need reading glasses!!

Surgery Discussion

Surgery takes approximately 10 minutes.
Relaxed/sedated with medication and eye numbed with drop.

- Can be done without IV in our surgical suite.

Expect to be “awake” but comfortable.
Through small incision (less than 1/8 inch) lens is broken into dust size particles and removed with gentle vacuum.
Small lens placed through same small incision.
Lens structure has no nerves so no pain with surgery and no feeling of lens in the eye.

Surgery Discussion

Drops are used on tapering schedule for 4 weeks per eye.
Back to normal activities the next day.
Limit strenuous and vigorous activities for a week.
Ok to bend and lift light objects.
Minimal risk of bleeding

- We are stopping blood thinners in MIGS cases.

Cataracts do not grow back.

Risks Discussion

Risks that I cover during my discussion:

- Infection
- Retinal Detachment
- Bleeding – very low, don’t stop blood thinners
- Swelling – temporary cause of blurred vision after surgery
- Floaters may be more obvious
- Some patient see edge of lens

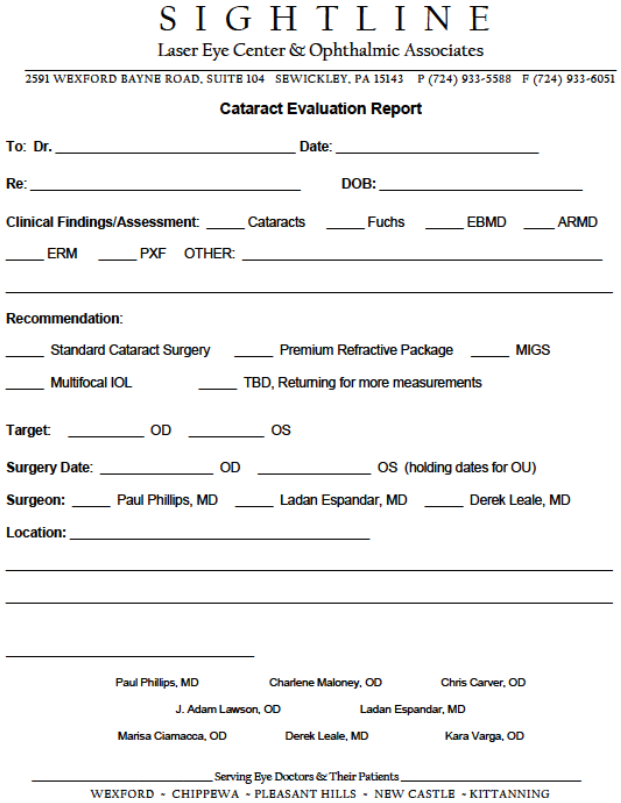
Risks Discussion

Case specific risks:

- EBMD – may require SLK if not satisfied with vision
- Fuchs – more likely to have post op corneal edema
- Ectasia – may require rigid lenses for best bision
- Pseudoexfoliation – risk of zonular weakness, more difficulty placing IOL, possible capsular tension ring
- Posterior Polar – risk of capsular tear and possible 2nd sx
- High myopia – increased risk of RD (with and without sx)
- Set expectations with any other pathology

Communication we send at conclusion of evaluation:

Pertinent findings
IOL type
Target outcomes
Dates of surgery
Surgeon
Location of surgery



SIGHTLINE
Laser Eye Center & Ophthalmic Associates

2591 WEXFORD BAYNE ROAD, SUITE 104 SEWICKLEY, PA 15143 P (724) 933-5588 F (724) 933-6051

Cataract Evaluation Report

To: Dr. _____ **Date:** _____

Re: _____ **DOB:** _____

Clinical Findings/Assessment: ____ Cataracts ____ Fuchs ____ EBMD ____ ARMD

____ ERM ____ PXF OTHER: _____

_____

Recommendation:

____ Standard Cataract Surgery ____ Premium Refractive Package ____ MIGS

____ Multifocal IOL ____ TBD, Returning for more measurements

Target: _____ OD _____ OS

Surgery Date: _____ OD _____ OS (holding dates for OU)

Surgeon: ____ Paul Phillips, MD ____ Ladan Espandar, MD ____ Derek Leale, MD

Location: _____

_____

_____

_____

Paul Phillips, MD Charlene Maloney, OD Chris Carver, OD
J. Adam Lawson, OD Ladan Espandar, MD
Marisa Ciamacca, OD Derek Leale, MD Kara Varga, OD

Serving Eye Doctors & Their Patients

WEXFORD • CHIPPEWA • PLEASANT HILLS • NEW CASTLE • KITTANNING

Largest fish caught this weekend by yours truly!!

Comanaging Cataracts: From Your Office and Back Again.

Paul Phillips M.D.

Sightline CE 2024

Financial Disclosure

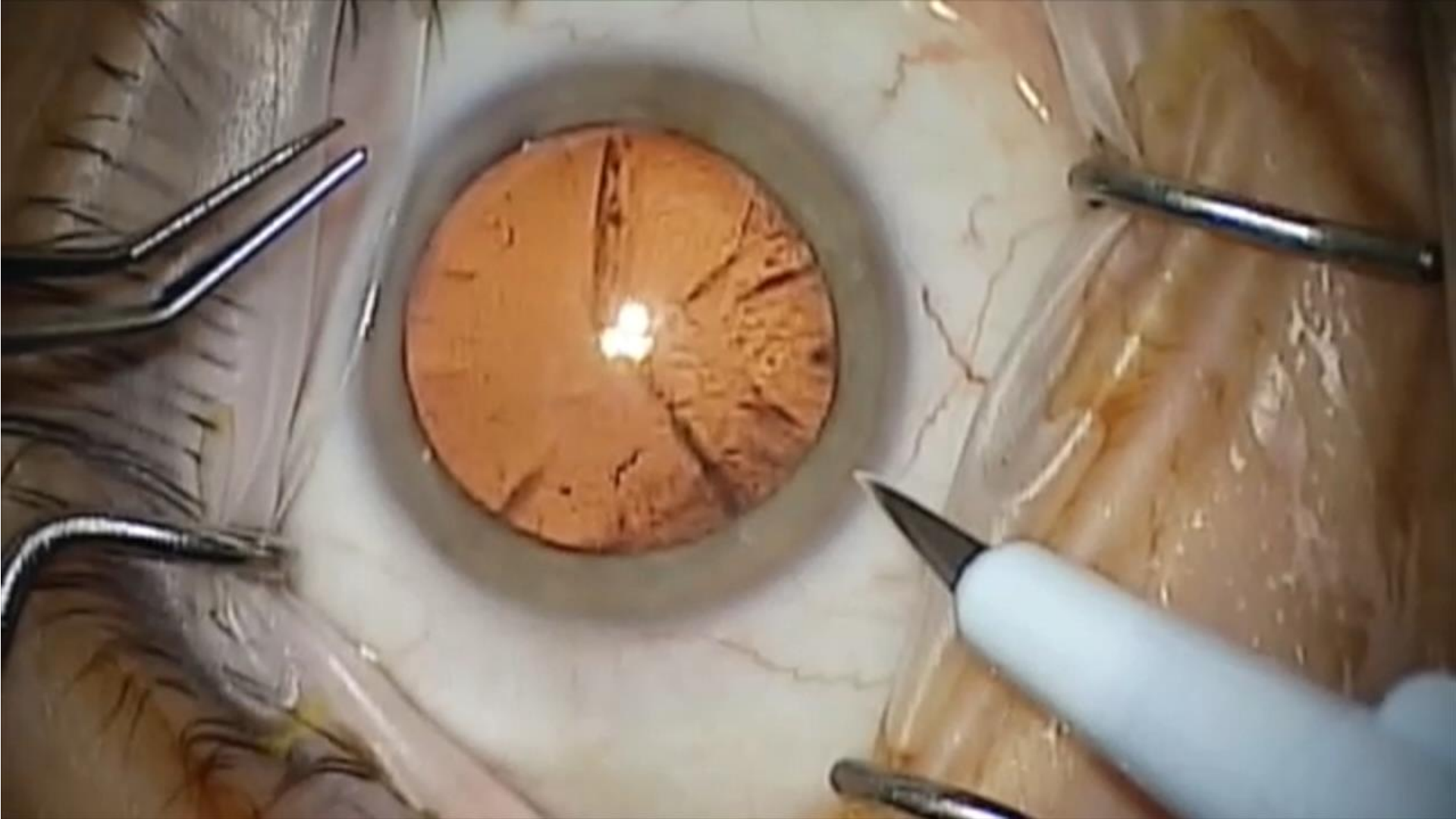
1. I have no financial interests to disclose

Goals of Talk

- Discuss important pre-operative cataract findings
- Video Demonstrations:
  - Cataract surgery
  - Specific intra-operative issues and considerations in complex cataracts
- Discuss post-operative issues
- Post-operative issues that may require intervention

Pre-Operative Evaluation of the Cataract Patient

- Identification of important pathology
  - Patient Education
  - Help co-managing ophthalmologist to identify issues
- Some examples of pre-op conditions that affect surgery or outcomes
  - Endothelial Dystrophies (Fuchs)
  - Zonulopathies (Ectopia Lentis)
  - Posterior Polar Cataract
  - Uveitis history
  - Intumescent-white lens
  - Floppy Irises (Flomax and Narrow angles)



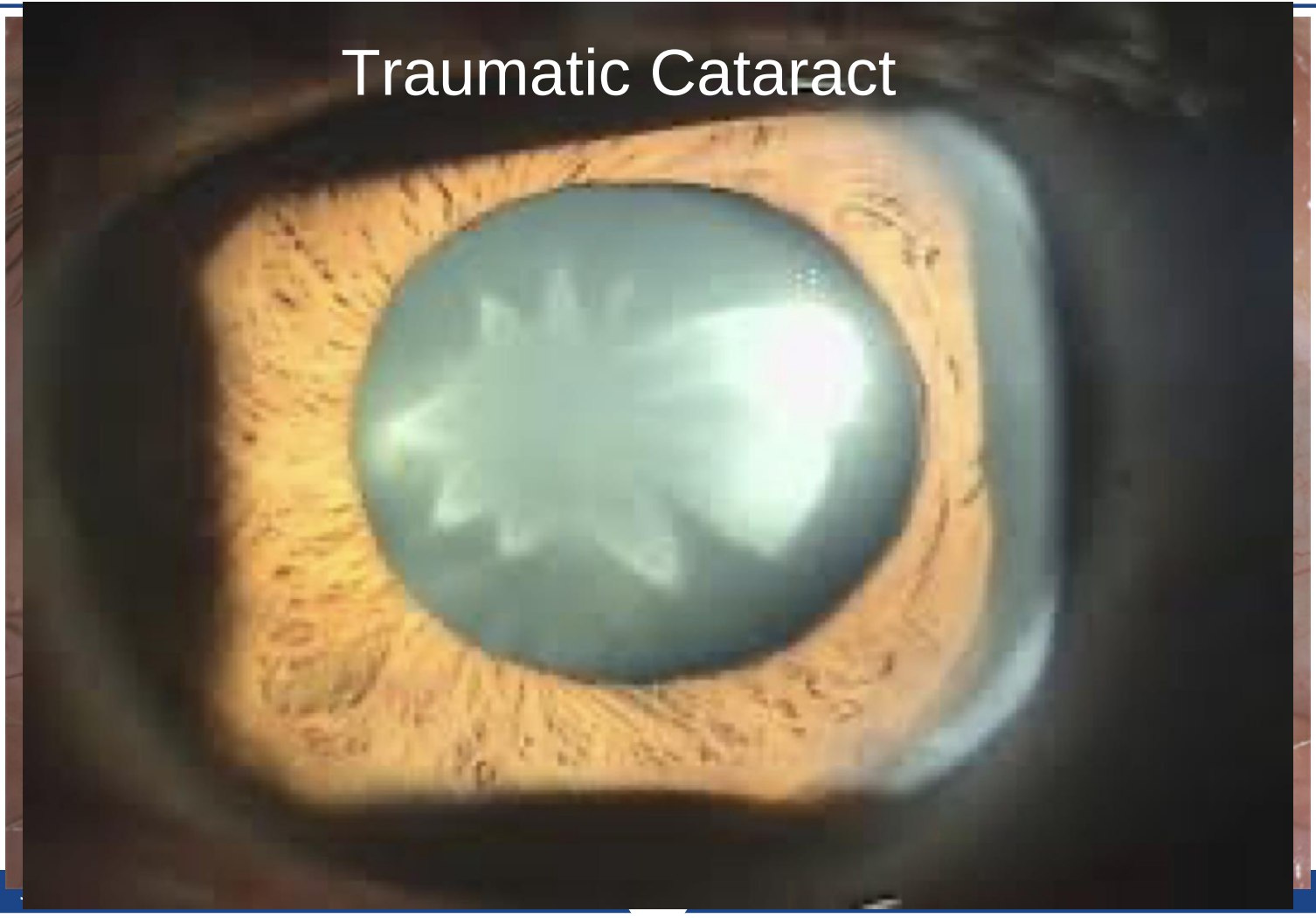
I know you won’t believe it, but this is the bigger of the two fish I caught this weekend!!

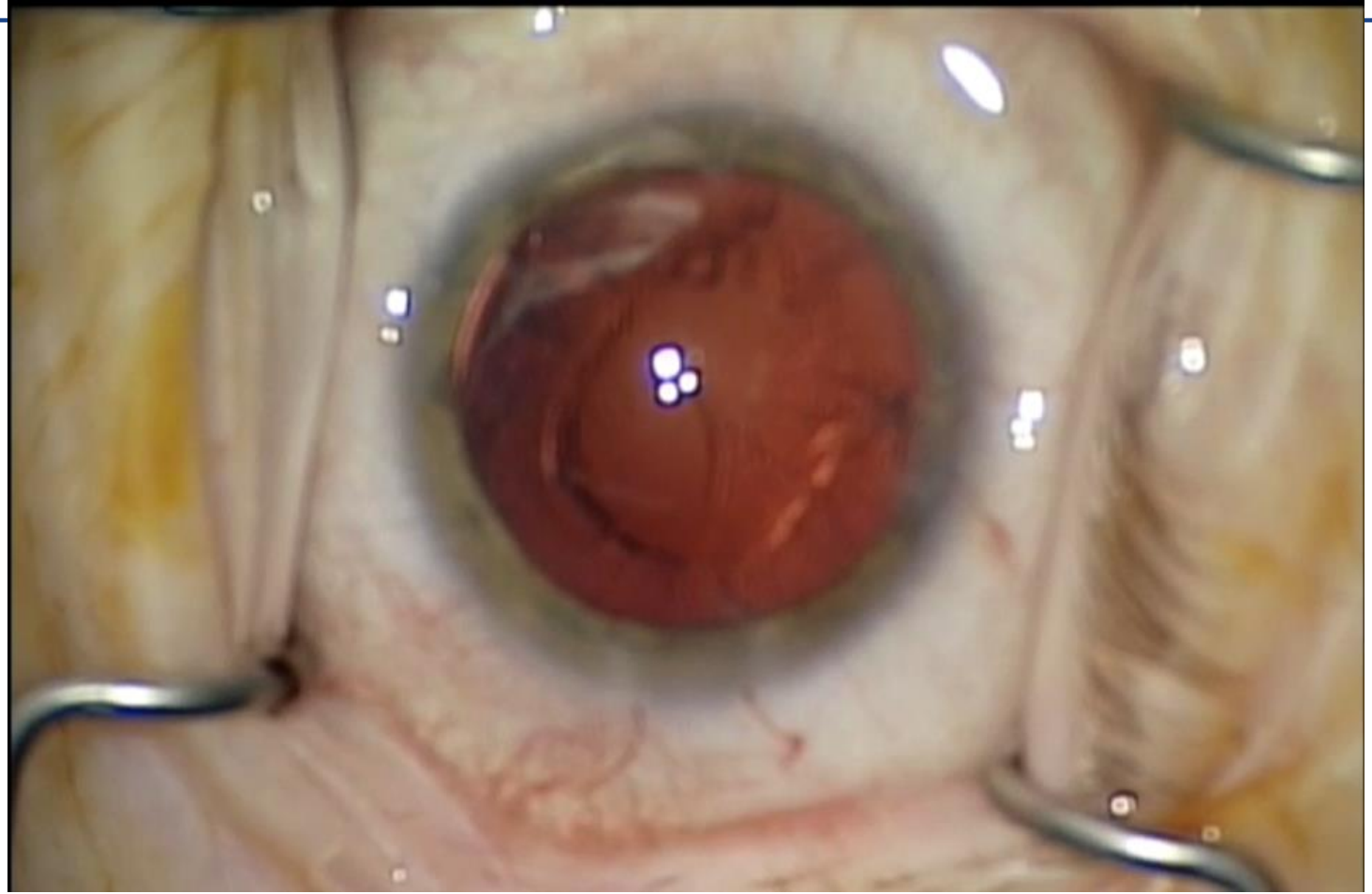
Fuchs Dystrophy

Zonulopathies and Ectopia Lentis

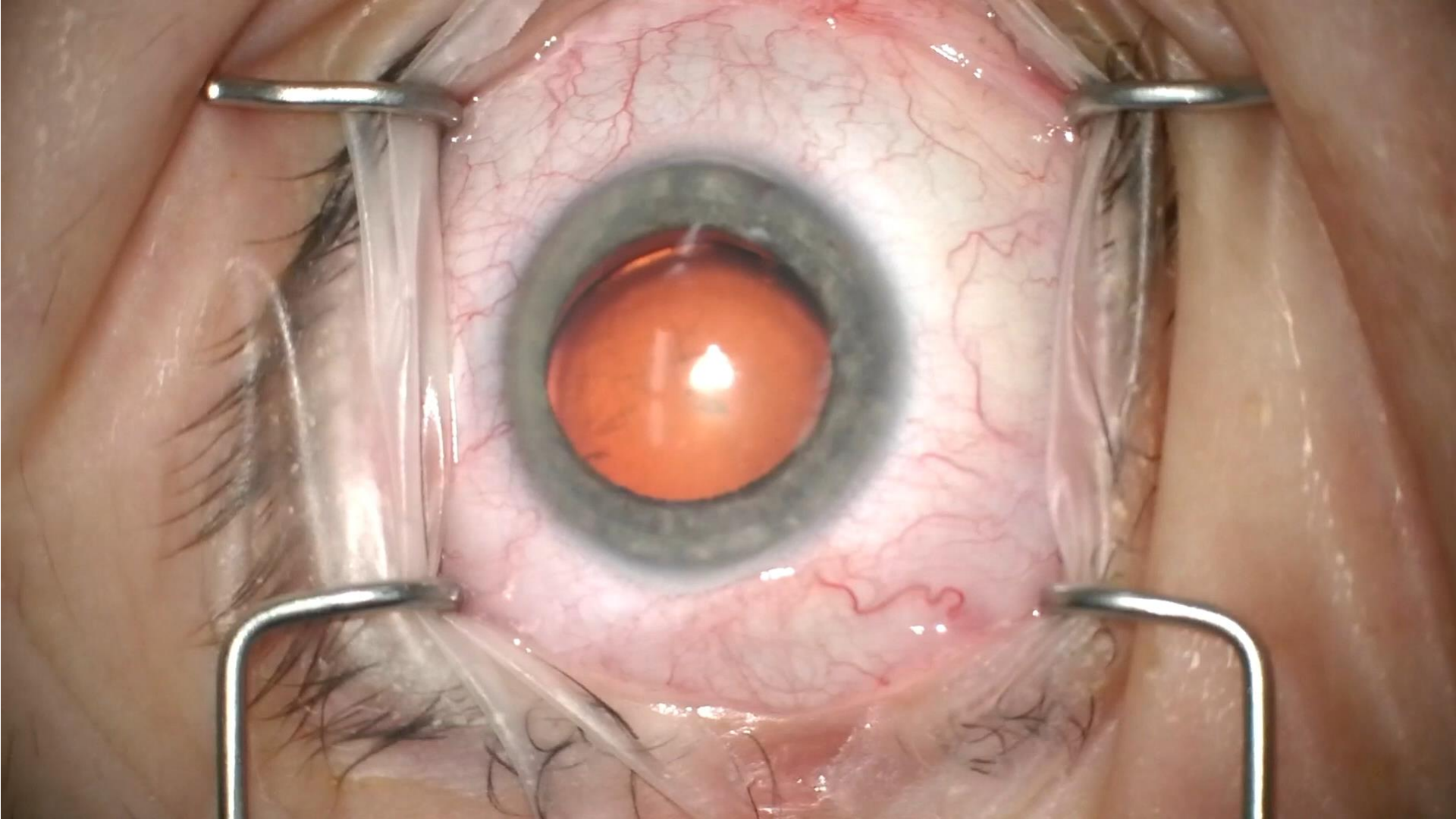
- Ocular conditions
  - Pseudoexfoliation (PXF) (most common zonulopathy)
  - Trauma (most common cause of Ectopia Lentis)
  - Simple Ectopia Lentis (mutations in ADAMSTL4 or FBN1 gene leads to degeneration of zonular fibers.)
  - Aniridia, Magalocornea, Axonfeld Riegers, Congenital glaucoma, Syphillis and others…

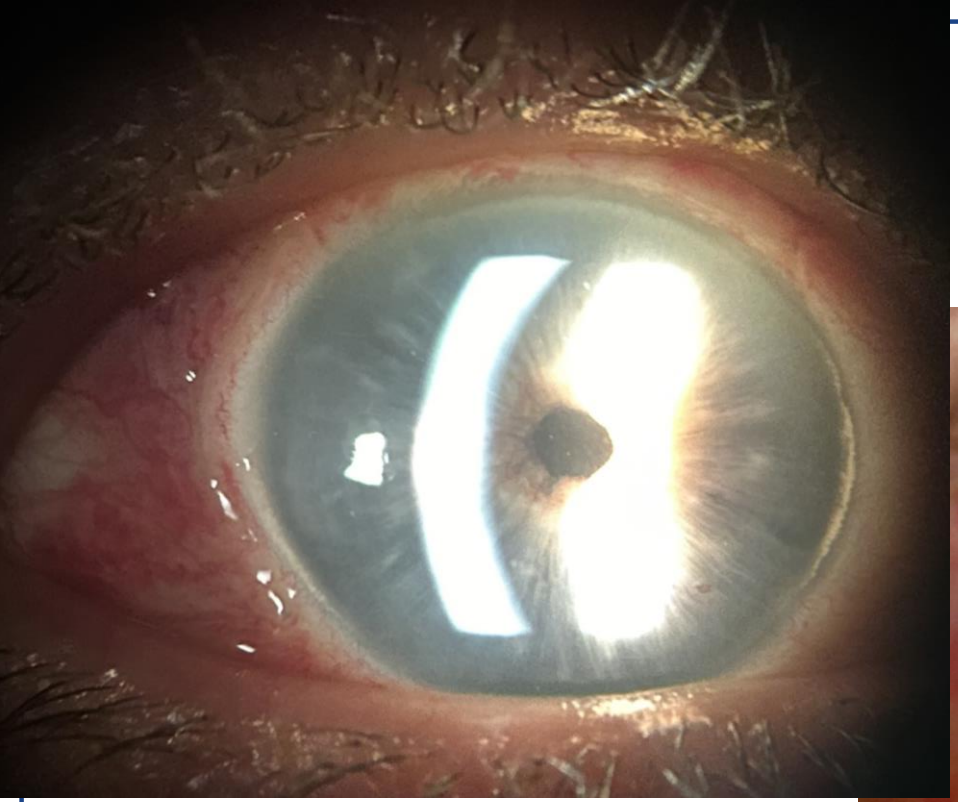
Traumatic Cataract

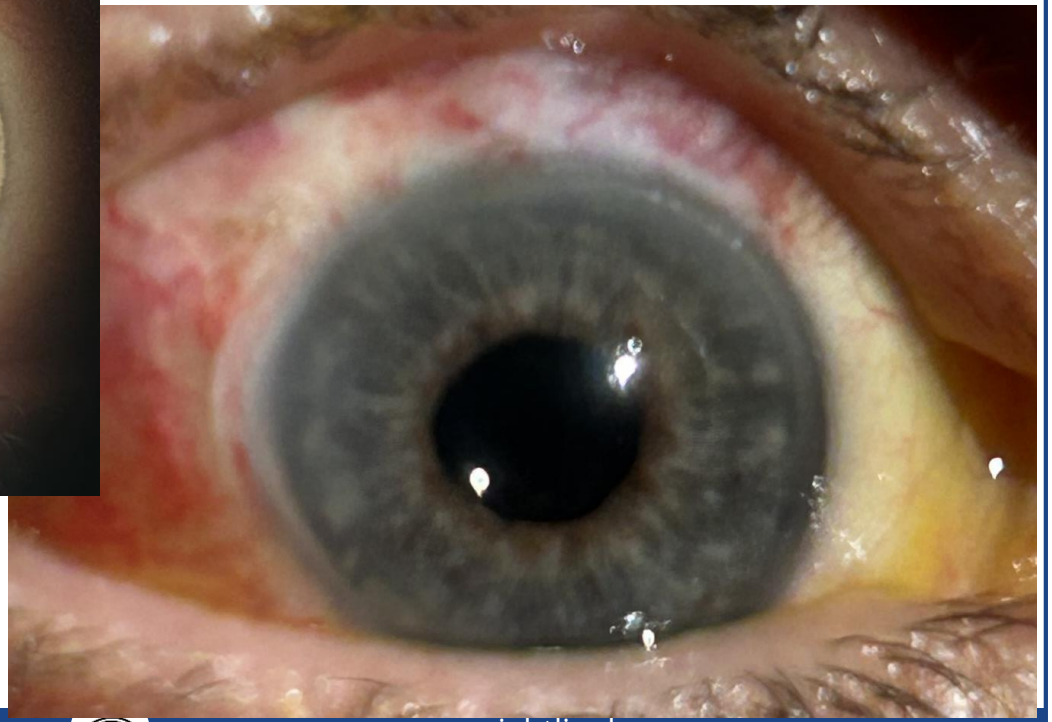




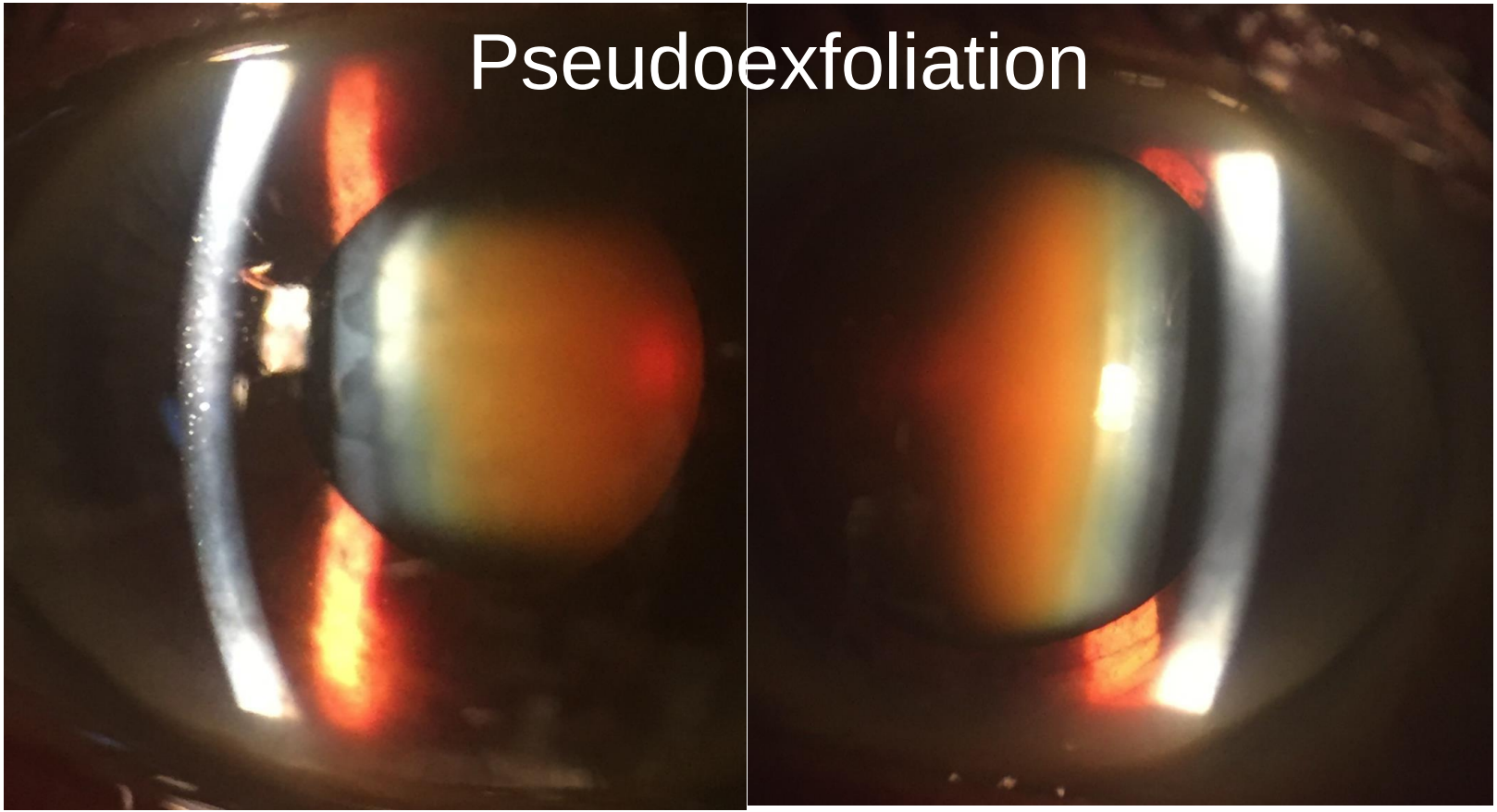
Quadrant of zonule loss







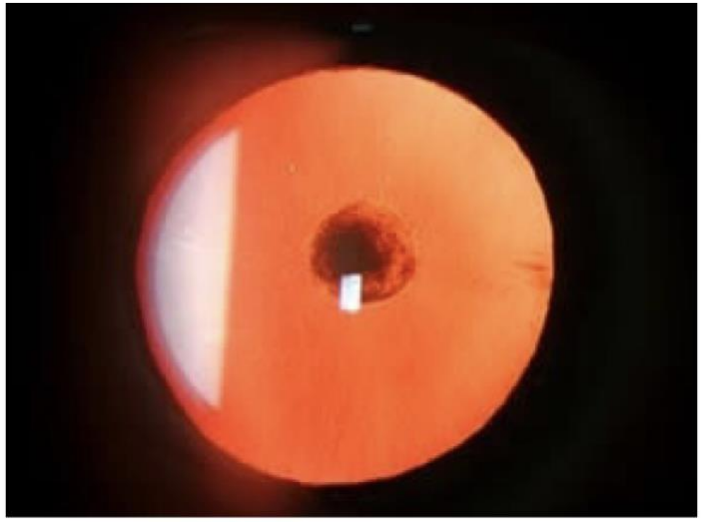
Pseudoexfoliation

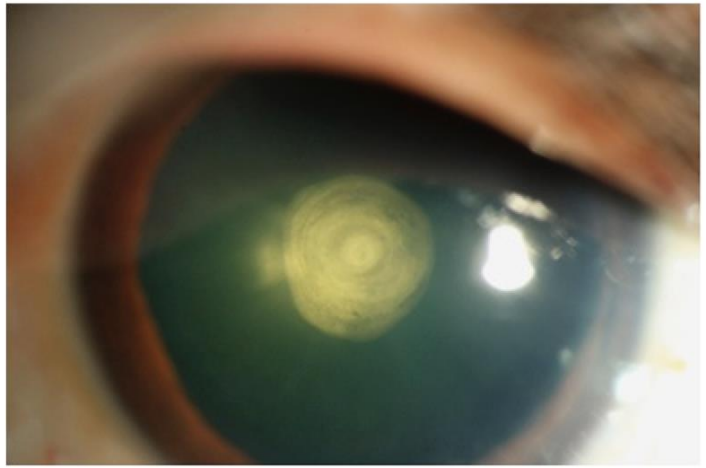


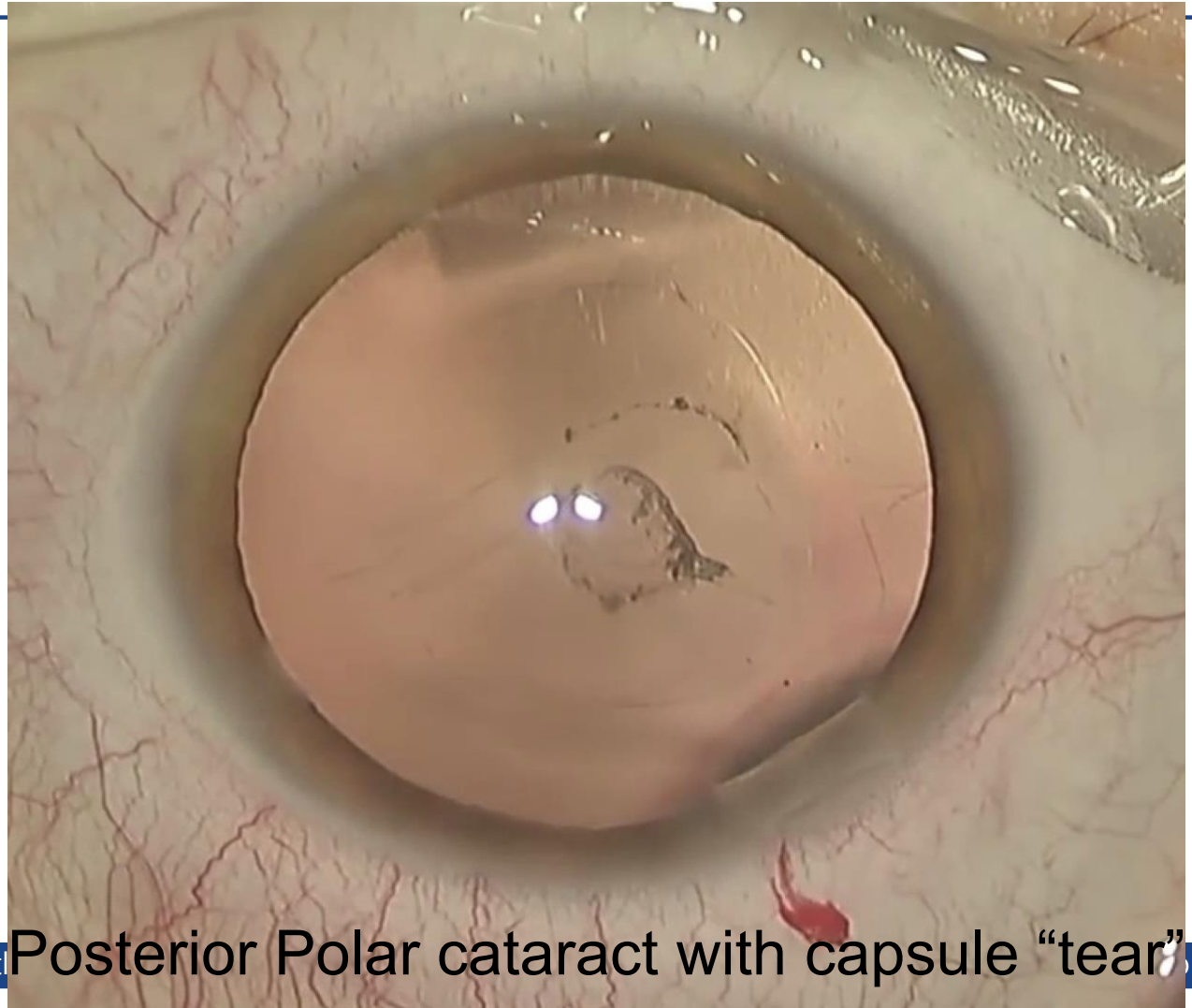
…often Asymmetrical

Posterior Polar Cataract

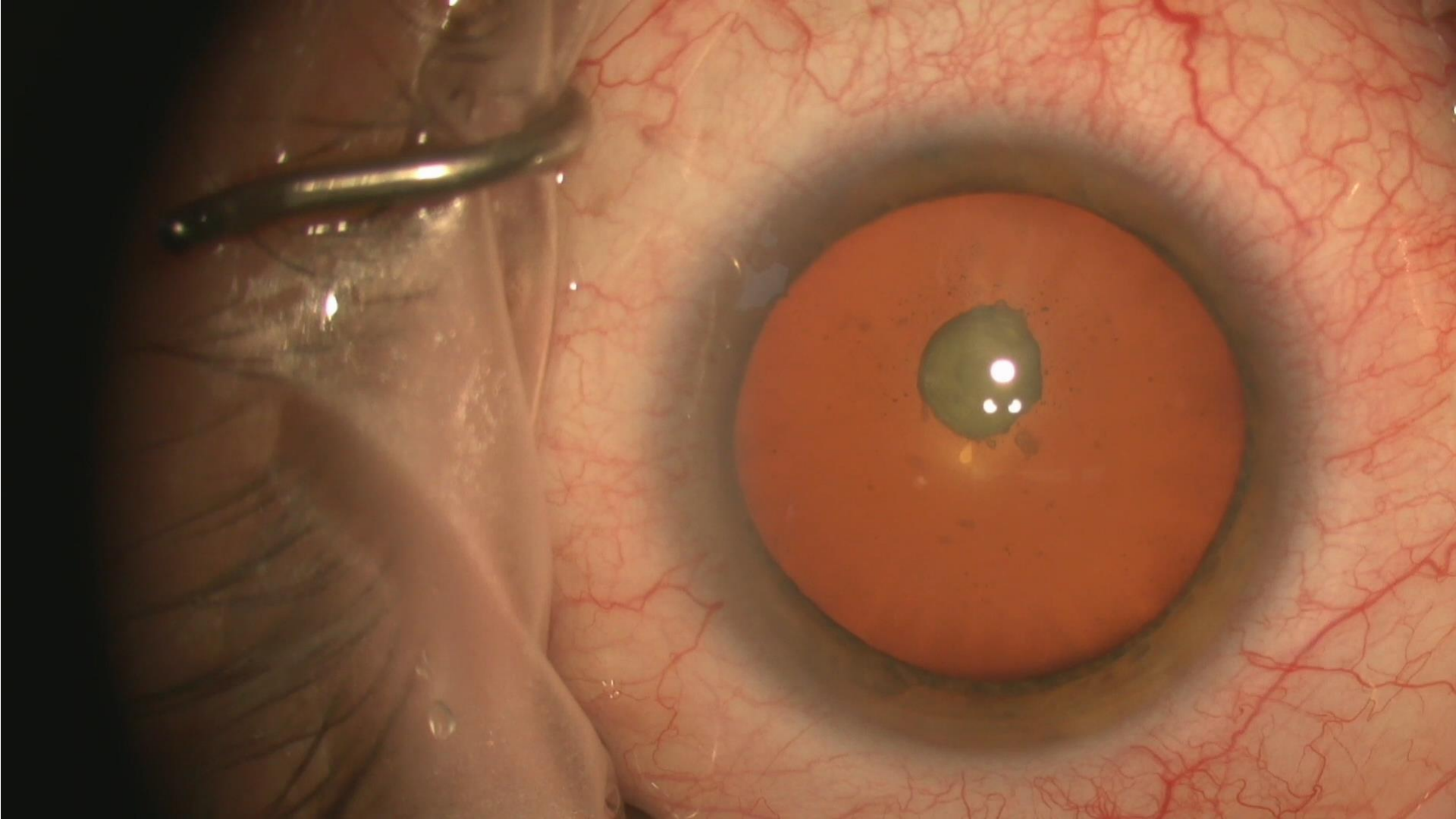
- Bilateral congenital cataracts
- Autosomal Dominant
- Central dense opacity with “whorl-like” appearance
  - Stationary - Well circumscribed
  - Progressive - Concentric ring appearance
  - Rate of posterior capsule rupture: 26%. Due to:
    - Adherence of cat to capsule
    - Thinned or absent capsule below lesion



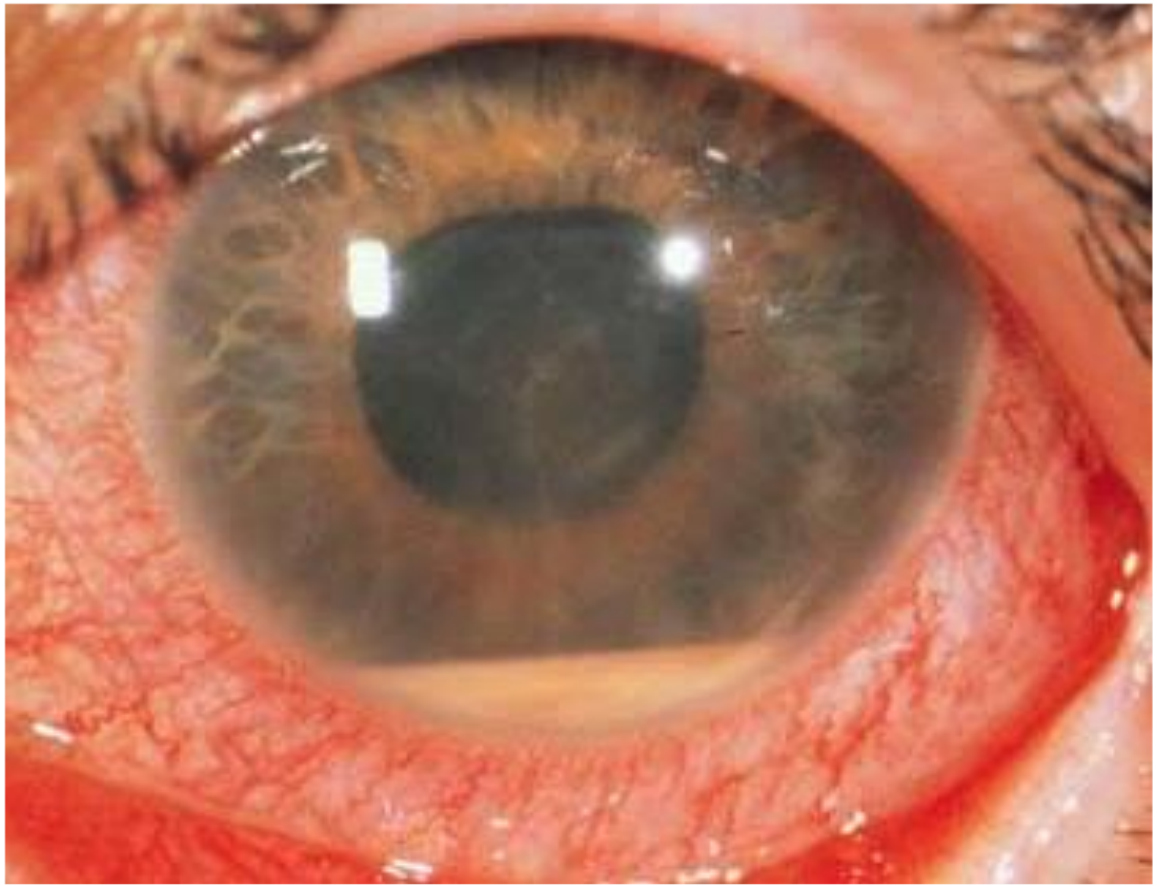




Posterior Polar cataract with capsule “tear”



Uveitis



Uveitis and Cataract Surgery

- Treatment depends on the cause *and* severity of the uveitis condition…
  - Linked to systemic causes (HLA-B27, Sarcoidosis, IBD…)
  - Linked to HSV or VZV
  - (Severe vs. Mild) or (Multiple vs. Single) episode
  - Bilateral?
  - Chronic?
  - IDEALLY patient is being treated for systemic conditions and is in an “ocular quiescent” period for 3-4 months.

Cataract Patient with History of Uveitis

- Severity of Uveitis Guides Treatment
  - If one mild unilateral previous episode
    - Start steroids before surgery (3 days)
    - More potent Steroid (Durezol) or More frequent dose post-op
  - If multiple mild episodes or single mild bilateral episode
    - Oral Steroid (Pred 60-80mg) Before and Tapered after.
    - Slower taper of topical Steorid
  - If severe past episode or chronic uveitis
    - Oral Steroid as above
    - Consider IV Solumdrol during surgery or Subtenon's Kenalog
    - Even slower taper of topical steroid to baseline

Cataract Patient with History of Uveitis

- In all cases:
  - Watch carefully after discontinuation of steroids for rebound uveitis and CME.

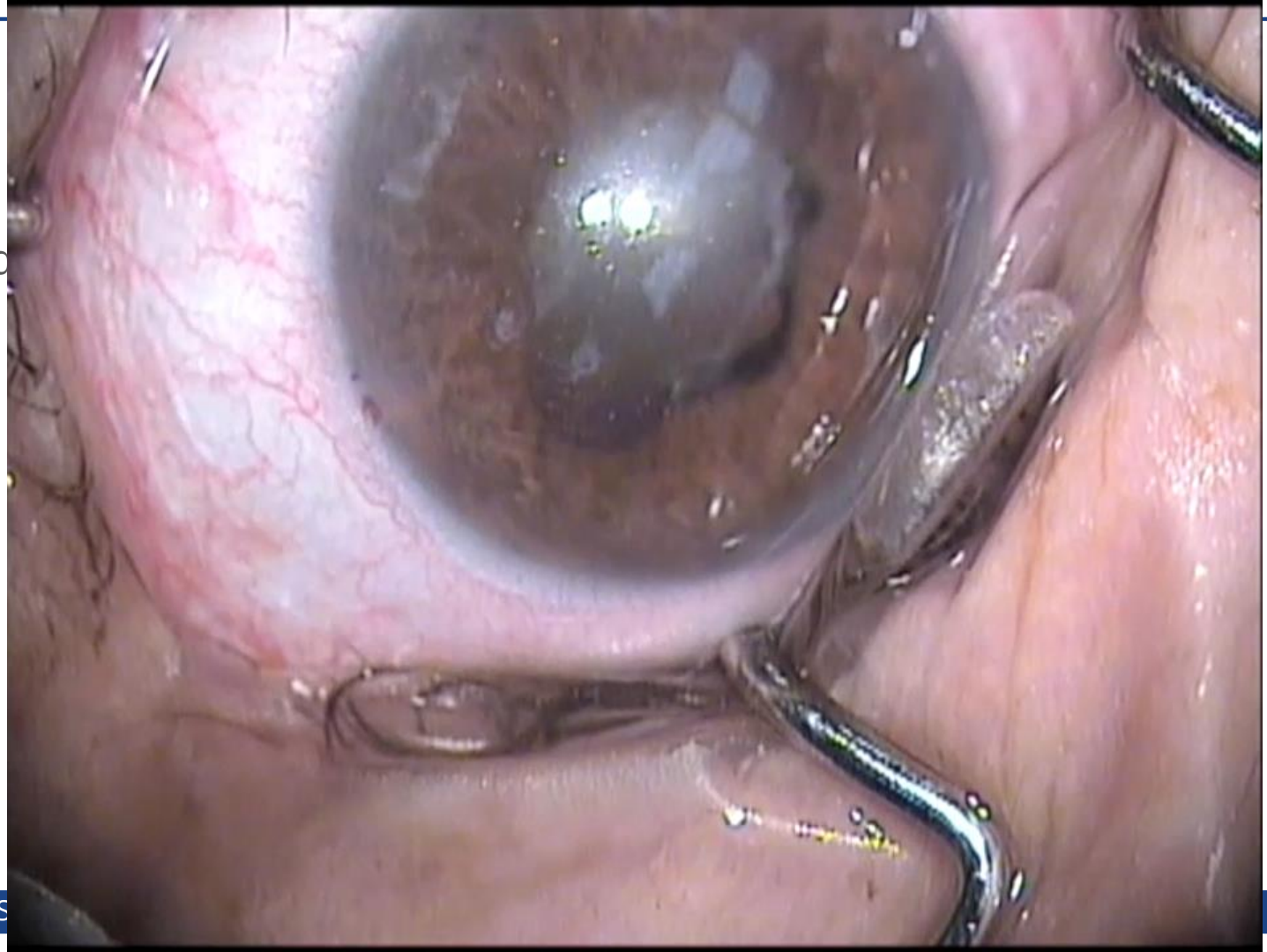
Cataract - History of HSV or VZV Uveitis

- Treatment is the same as for uveitis caused by systemic disease with the addition of an oral antiviral:
  - **Valacyclovir** 1000 TID, 1 week pre and 1 week post surgery, then consider low dose (500qday) for a few weeks. (Acyclovir can also be used)
  - Really only anecdotal evidence that this is necessary…

Cataract Patient with History of Uveitis

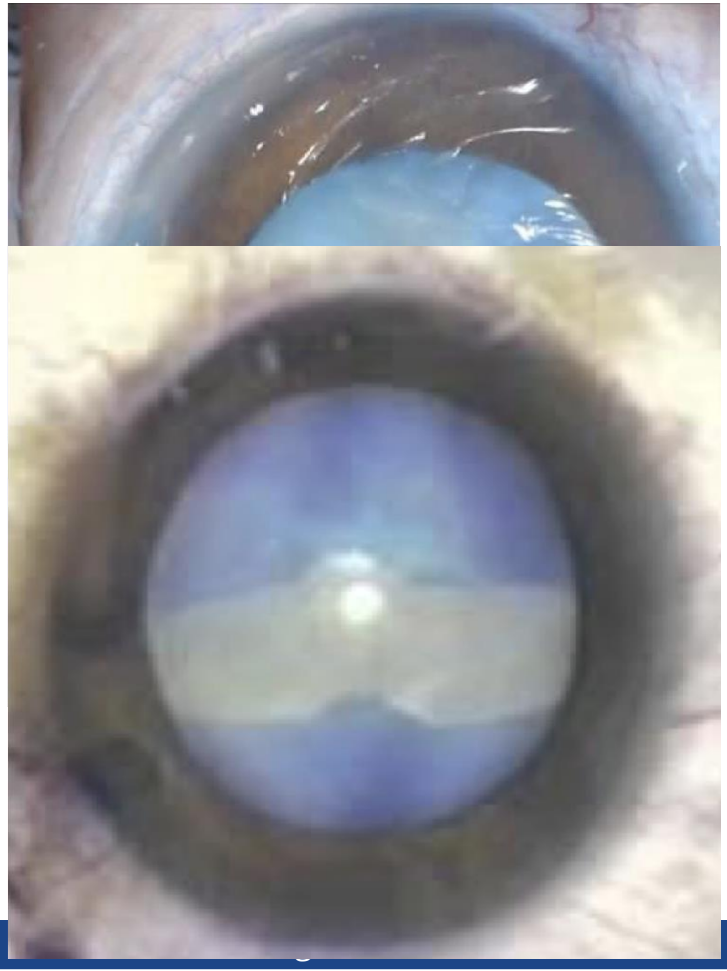
- Other Surgical Considerations
  - **Posterior synechiae** are often present and must be lysed during surgery.
  - **Careful manipulation of iris**, when possible, is ideal to avoid unnecessary trauma and increased blood aqueous barrier break down.
  - **Low endothelial cell counts** may be present due to previous inflammation. Low phaco energy and gentle surgical manipulation is ideal.

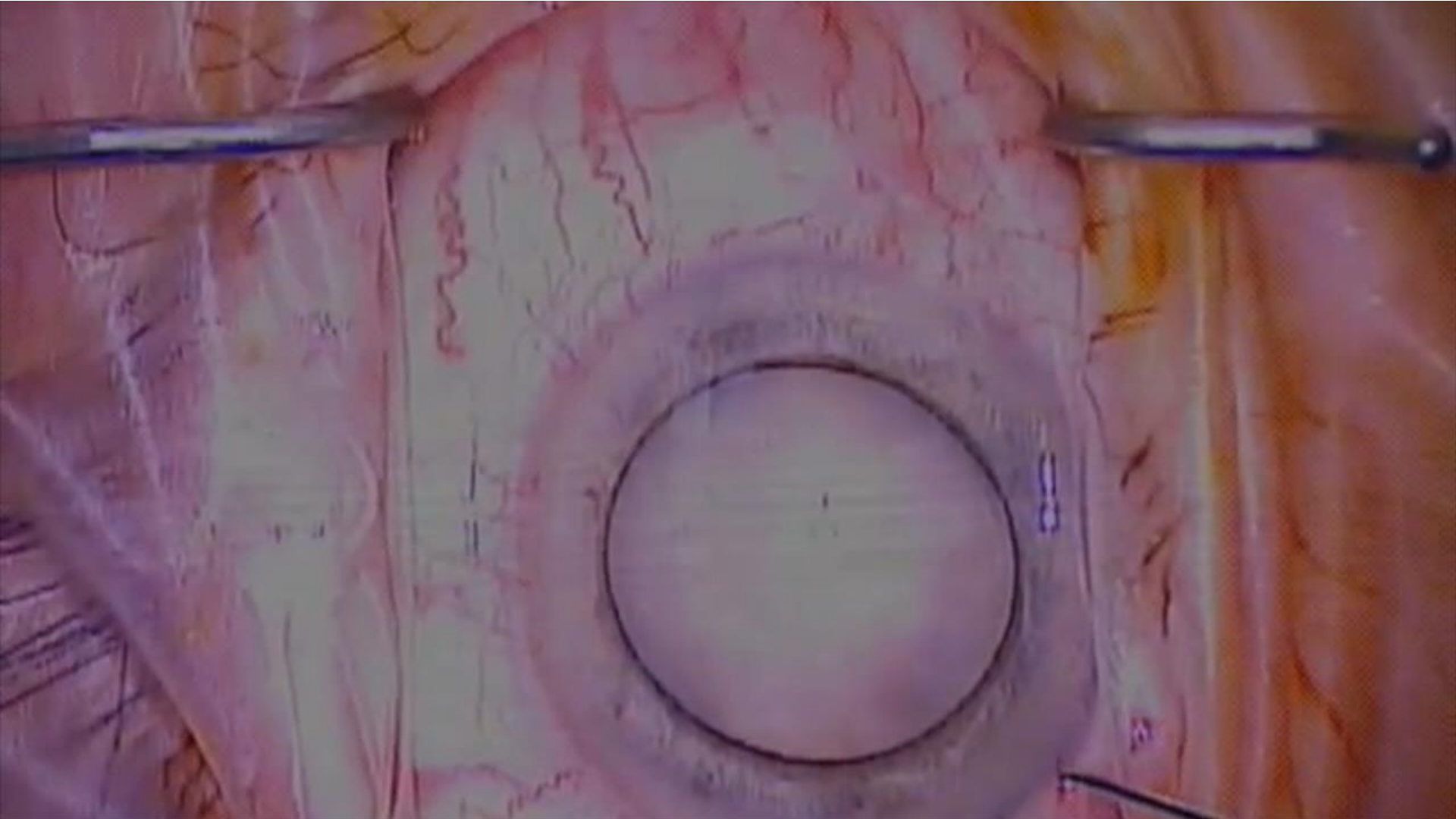
- Vid



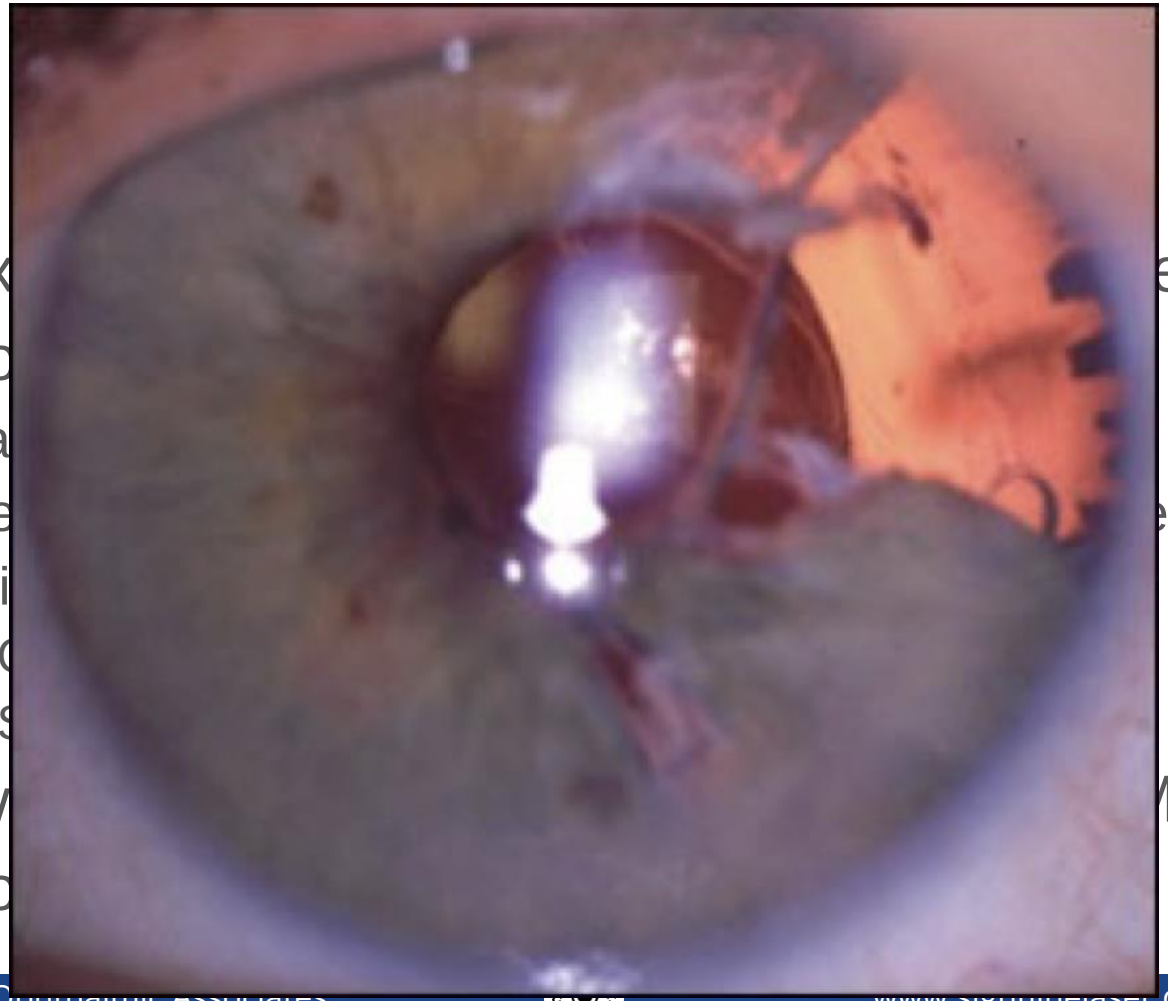
Intumescent Cataract

- Mature cataract that becomes swollen due to osmotic effect of





“Floppy



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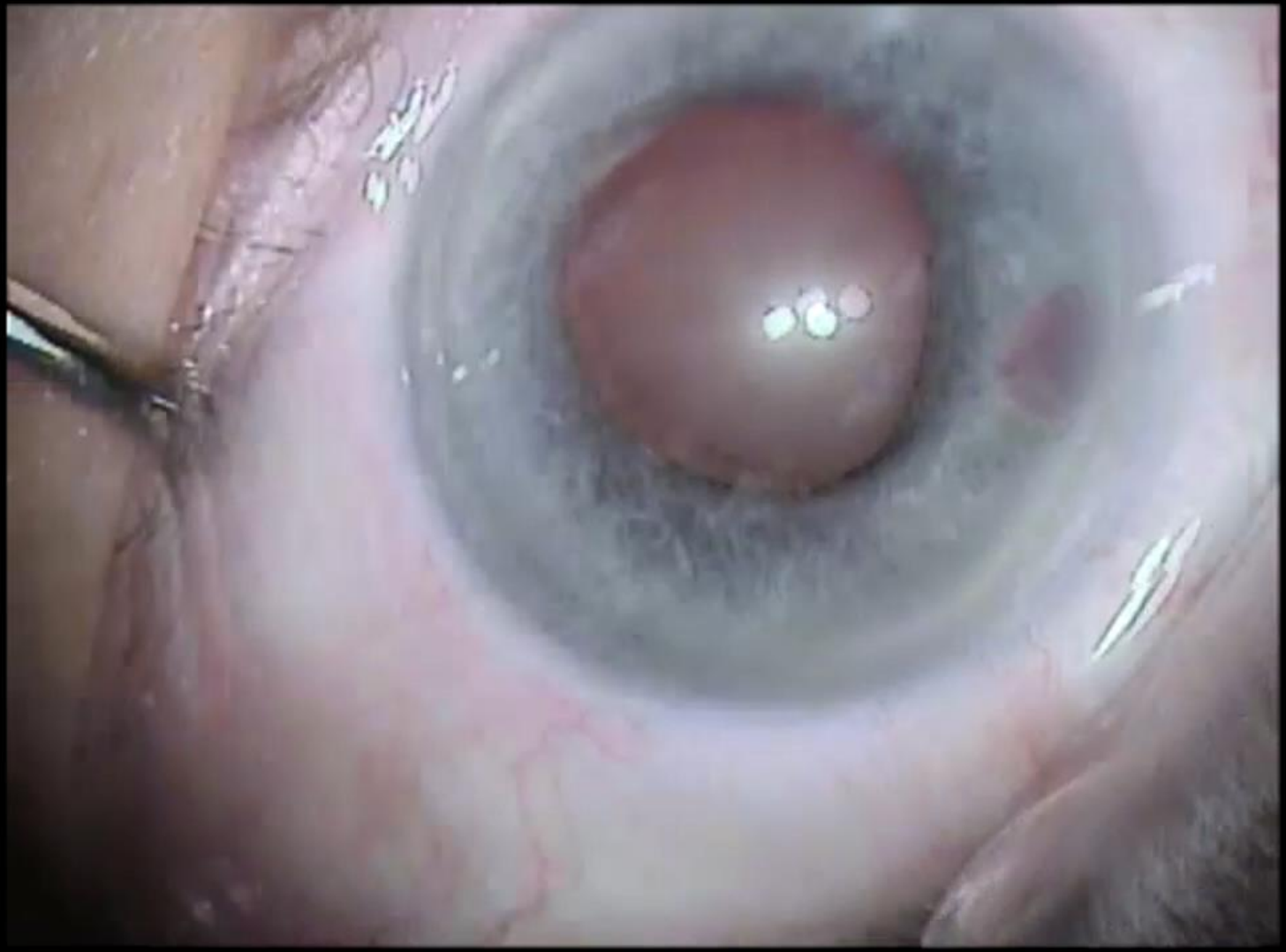
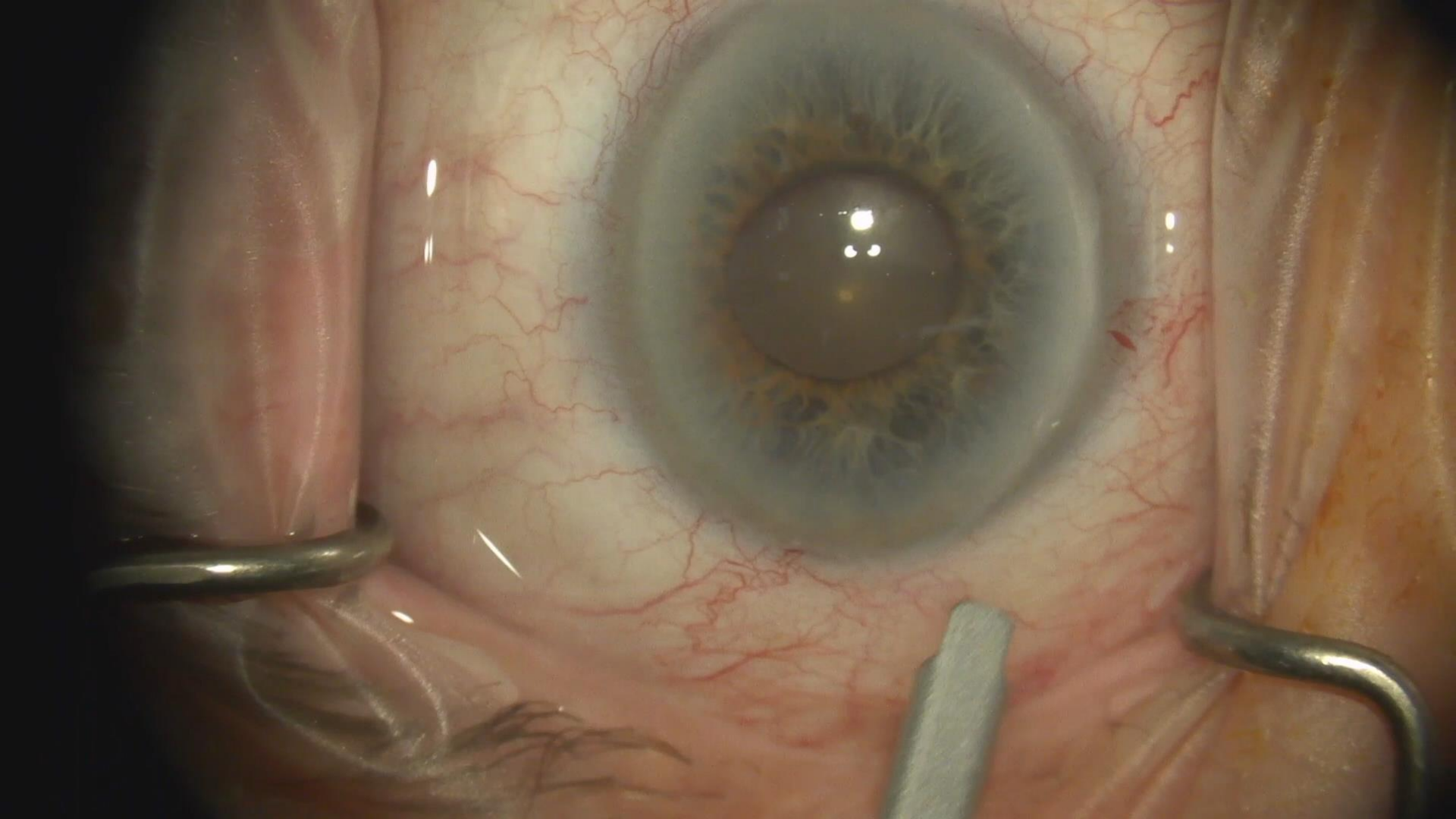




Another big rainbow Chris caught.

Post-Operative Evaluation

Post-Op 1 Day “Issues”

Post-op Day 1 “Issues”

- Wound leak
  - Suspect if low IOP (<10mmHg…)
  - Test wounds with wet fluorescein strip
  - Inform surgeon
  - Bandage contact lens
  - Give Aqueous suppressant drops: Timolol, Brimonidine, Dorzolamide etc.
  - Educate patient NOT to rub
- Excessive inflammation
  - Always consider Endophthalmitis (but not likely day one…)
  - TASS - usually inflammation in associating with SEVERE corneal edema
  - Discuss with surgeon, Increase steroids and refer back or to retinal specialist
- Corneal Edema - may be normal - pachymetry can be useful for following
- Elevated IOP

Post-op day 1 “issues” – Elevated IOP

- Elevated IOP no glaucoma:
- If IOP<35mmHg - usually no treatment. Possibly add IOP drop.
- If IOP 35-55mmHg
  - Treat with IOP drops and recheck in 1-2 hours
  - If improving significantly continue meds and follow up 1 wk or possibly sooner.
  - If not improving then consider Diamox 500mg follow up next day.
- If IOP >55mmHg – Was the surgery complicated? Likely there is retained viscoelastic, blood, vitreous etc…
  - Treat with drops as above and Diamox 500mg and recheck in 1-2 hours
  - Consider “burping wound” if pain and nausea…(Treat eye with Betadine prior to burping)
  - Follow up next day
- Elevated IOP and glaucoma: All of the above. Follow up next day

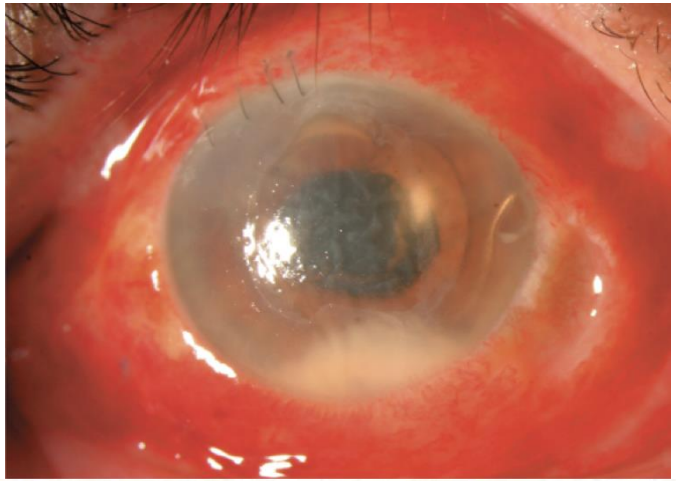
  …glaucoma surgeons often have significant pressure elevation after Trabeculectomy or Tube shunt surgery…

Post-Op 1 Week “Issues”

Post-Op Week 1 “Issues”

Endophthalmitis

- Consider if patient calls with worsened vision, pain or redness (not necessary to have all three!)
- Consider if significant or worsening cellular reaction
- If KP, FIBRIN, or Hypopyon = Endophthalmitis
- Increase antibiotics and steroids (q1/2hr) and emergent referral for “tap and injection” of antibiotics

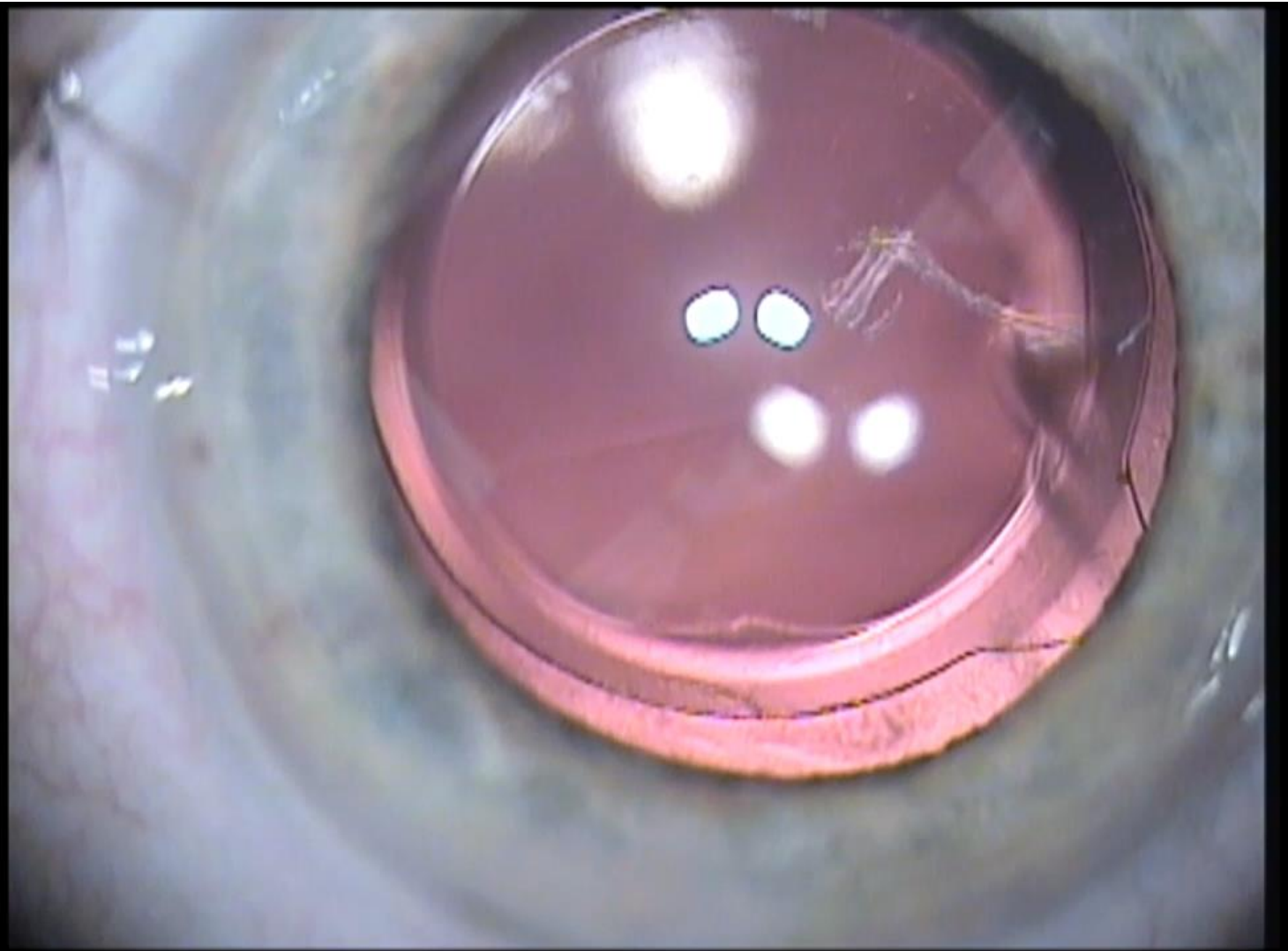


Post-Op Week 1 “Issues”

- **Retinal tears and detachments**
  - Must evaluate any patient with complaints of new flashes, floaters or peripheral visual disturbances - Dilation is required!
  - Look for vitreous debris or blood - “where there is smoke there is fire.”
- **New IOP elevation**
  - Treat and keep in mind possible early steroid response
- **Corneal edema**
  - Should be minimal at this point unless very dense cataract, complicated surgery or endothelial disease.
  - **If diffuse edema:** Look for associated intra-ocular inflammation.
  - **If focal edema:** Look for endothelial trauma
  - **If inferior edema:** Consider a retained lens fragment
    - Look carefully – With Gonioscopy for view of inferior angle.

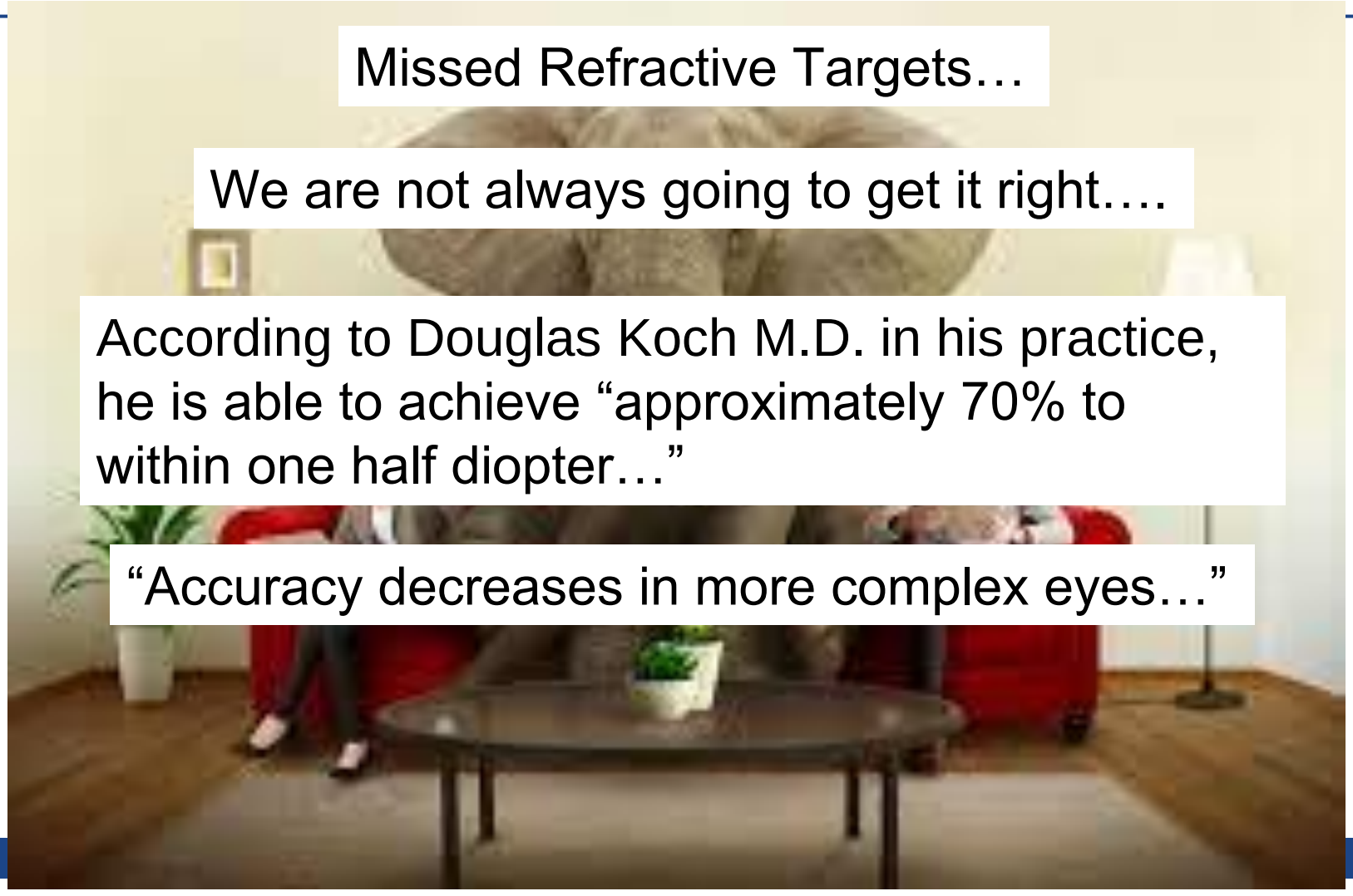
Post-Op Week 1 “Issues”

- **Scratched lens**
  - Now is a good time to take a close look at the lens. Most scratches or “dings” on the lens are asymptomatic.
  - Recognition of these findings may help in future if patient complains later of symptoms…



Post-op week 1 “issues”

- Missed refractive target
  - Refraction at this visit is important especially in first eye…
  - Inform surgeon to make possible adjustment in lens calculation for second eye
  - But, we take one week refractions with a “grain of salt.”



Missed Refractive Targets…

We are not always going to get it right….

According to Douglas Koch M.D. in his practice, he is able to achieve “approximately 70% to within one half diopter…”

“Accuracy decreases in more complex eyes…”

Post-op week 1 “issues”

- **Dysphtopsias**
  - Positive
    - Define symptoms: Rings/Halos vs. Streaks of light/Blur
  - Negative
    - Dark or missing vision “Arc shaped”
  - These symptoms *ALMOST* always will resolve…

Unhappy EDF or MF cataract patient…

- One of our greatest challenges is the a patient who returns to us[illegible] months after surgery, with[illegible] or glare symptoms and a mild posterior capsular opacification.

Is it the lens?

- Worse is when they are sent for a YAG laser without any detailed information from the referring eye care provider.

- So what can be done to avoid this outcome?

Unhappy EDF or MF cataract patient…

- More information is needed!
  - What exactly are the symptoms?
    - Blur?
      - Near?
      - Distance?
    - Positive dysphotopsia? - Halos, Shimmering light
    - Negative dysphotopsia? – Dark arc-shaped area…
    - Glare/Starburst?
  - When did problem start?

The exam of Unhappy EDF or MF Patient

- Be careful not let the patient stew…
- Examine eye closely
  - Tear film and cornea surface
  - Lens centration (rarely obvious and rarely the issue…)
  - Dilate and Look for capsule fibrosis or obvious wrinkles immediately and document (even if clear!)
  - Look at retina and consider OCT for missed macular pathology and CME.
  - Try not to conjecture too much if there is a finding…
  - Call surgeon's office and discuss!

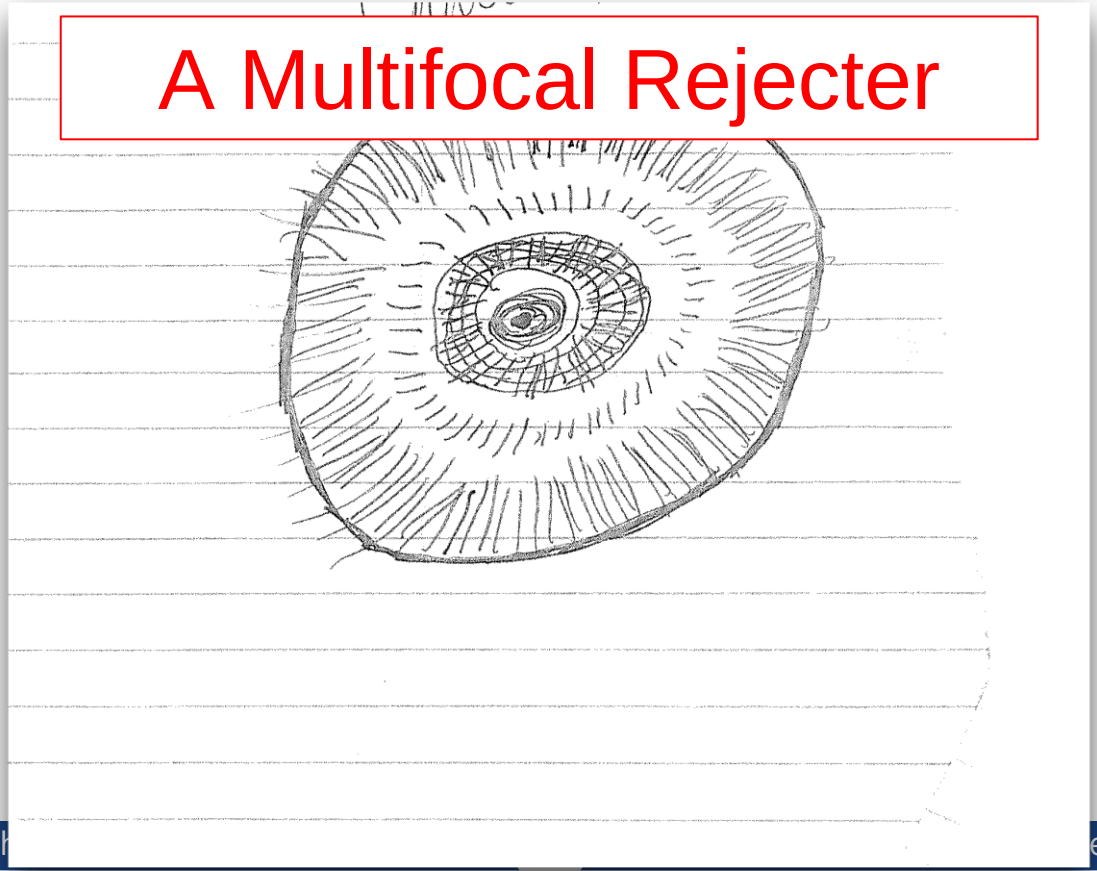
The exam of Unhappy EDF or MF Patient

- Refract: Looking for residual sphere or cylinder
- If missed refractive target
  - Trial lenses or trial contact lenses to determine if symptoms resolve or improve.
  - Remember to be very clear with the patient that goal is NOT to have patient wear glasses or contacts…

The exam of Unhappy EDF or MF Patient

- If refractive target is good:
  - And mild to moderate halos or dysphotopsia symptoms:
    - Encourage the patient that these symptoms are common and RARELY won't resolve or improve with time…
    - In case of "Rings" or positive dysphotopsias, "This is how the lens works" and is normal at first...
  - If symptoms are SEVERE and disabling, return them to surgeon's office sooner rather than later (1-3 months). This is the case where a lens may need to be exchanged.

Unhappy Multifocal Patient Brings Drawing to Clinic 1 week after surgery with clear capsule…



The exam of Unhappy EDF or MF Patient

- If target is good and:
  - Near vision is problem. It is most likely an EDF lens
    - Hand holding and Time…
    - Use minus lenses (-2.00D) to show patient what they are gaining with the lens compared to monofocal.
    - I would discourage early use of reading glasses unless the patient has already made it clear they are willing to live with their result…

Post-Op 1 month “Issues”

Post-Op 1 month “Issues”

- Cystoid Macular Edema (CME)
  - Most common
    - After complex surgery (Vit loss, iris trauma, capsule rupture etc…)
    - In Diabetics
    - In Uveitic eyes
    - In eyes with Epiretinal Membrane (ERM)
- Initial treatment:
  - Start NSAID (if not already on) or increase dose
  - Increase steroid dose or strength
- If improving at one month: continue and treat for one month after resolution.
- If not improving or worsening: consider retinal consult for possible steroid or anti-VEGF injection.
- Keep in mind this is usually a self limit problem unless there is continued inflammation or vitreous traction

Post-Op 1 month “Issues”

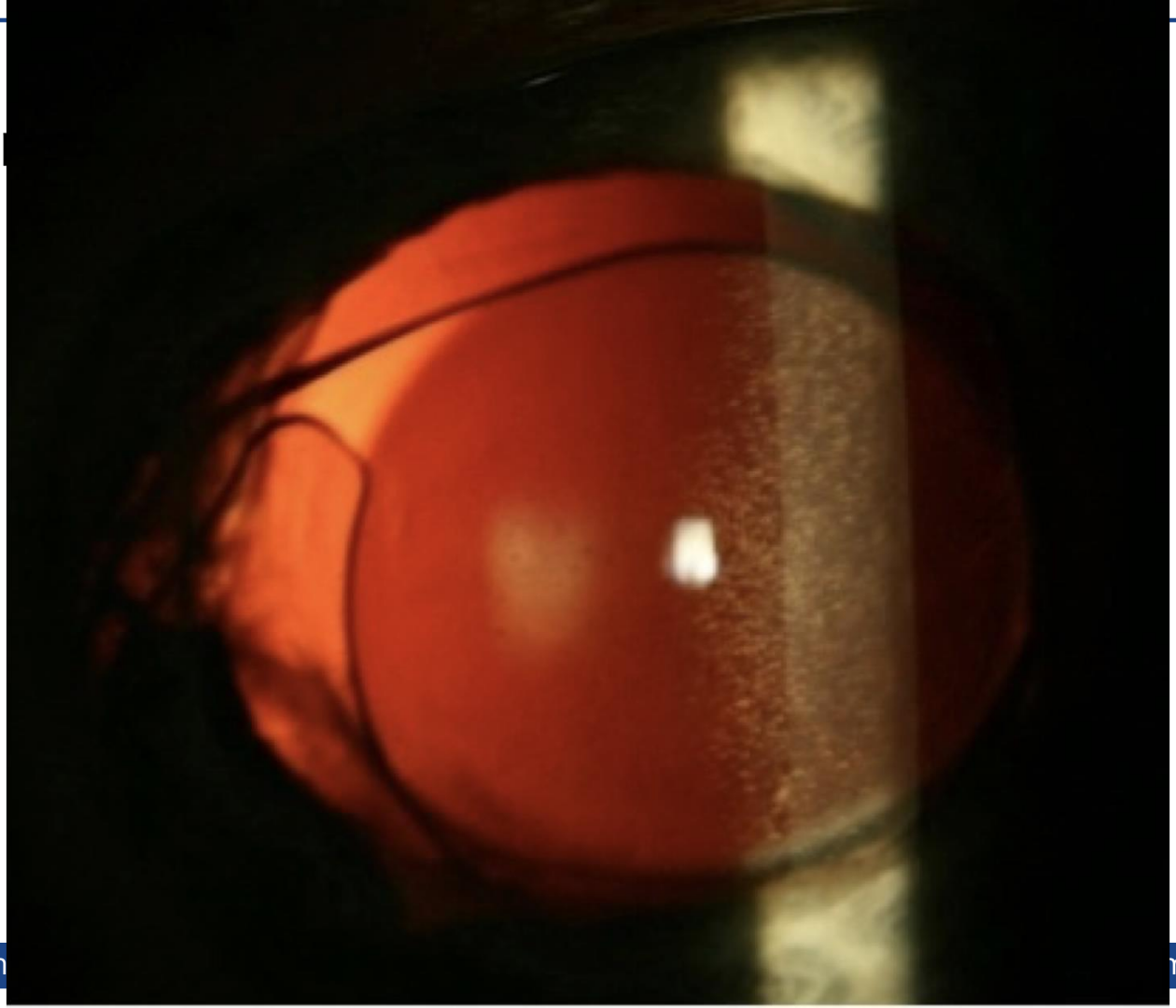
- Early Posterior Capsular Opacification (PCO)
  - Early YAG laser may have a higher incidence of CME
  - Ideal to wait a few months, but probably not a significant difference after one month.
  - PCO seems to affect vision more in MULTIFOCAL lenses, so if these patients were happy and begin complaining of vision issues, consider YAG.
    - This can be tricky: Determining “glare” complaints vs. “halos” as a cause of dissatisfaction is critical…

Post-Op Beyond 1 month “Issues”

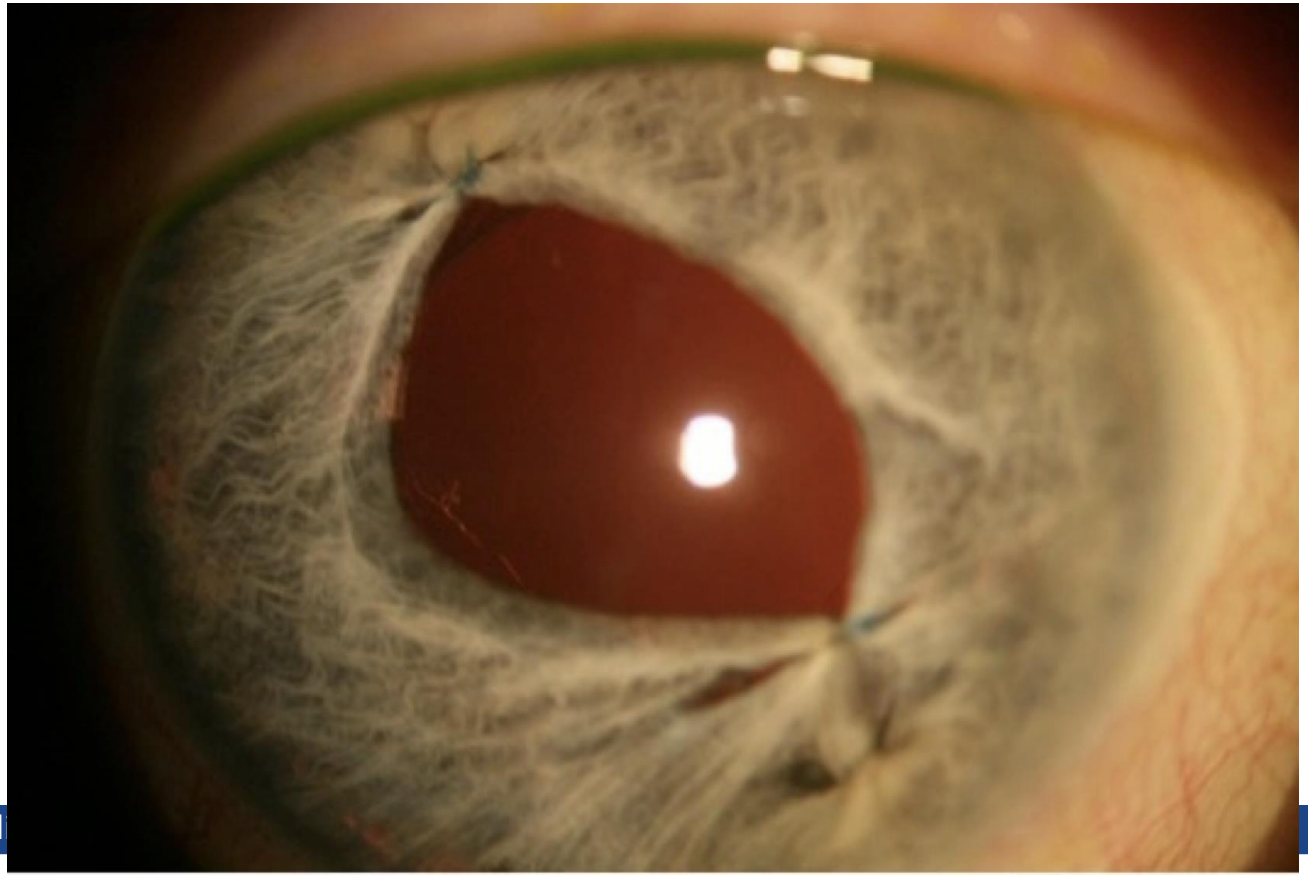
Post-op beyond 1 month “issues”

- Rebound iritis
  - Treat with steroids and NSAIDS
  - If rebound occurs multiple times or uveitis worsens despite treatment uveitis “work-up” is required.
  - If negative work-up, must consider indolent endophthalmitis = p. acnes
  - If infectious cause may require lens and capsule removal…
  - Consider Uveitis Glaucoma Hyphema (UGH) syndrome.
    - Especially if “complex” surgery required a sulcus positioned lens
    - One piece lenses cannot reside in the sulcus!
    - Essentially 100% of these will eventually cause problems and require explantation…

UGH Sy



1 month Post-Op UGH repair



Post-op beyond 1 month “issues”

- Rebound iritis
  - Consider retained lens fragment: Gonioscopy should be performed to rule this out even months after surgery.

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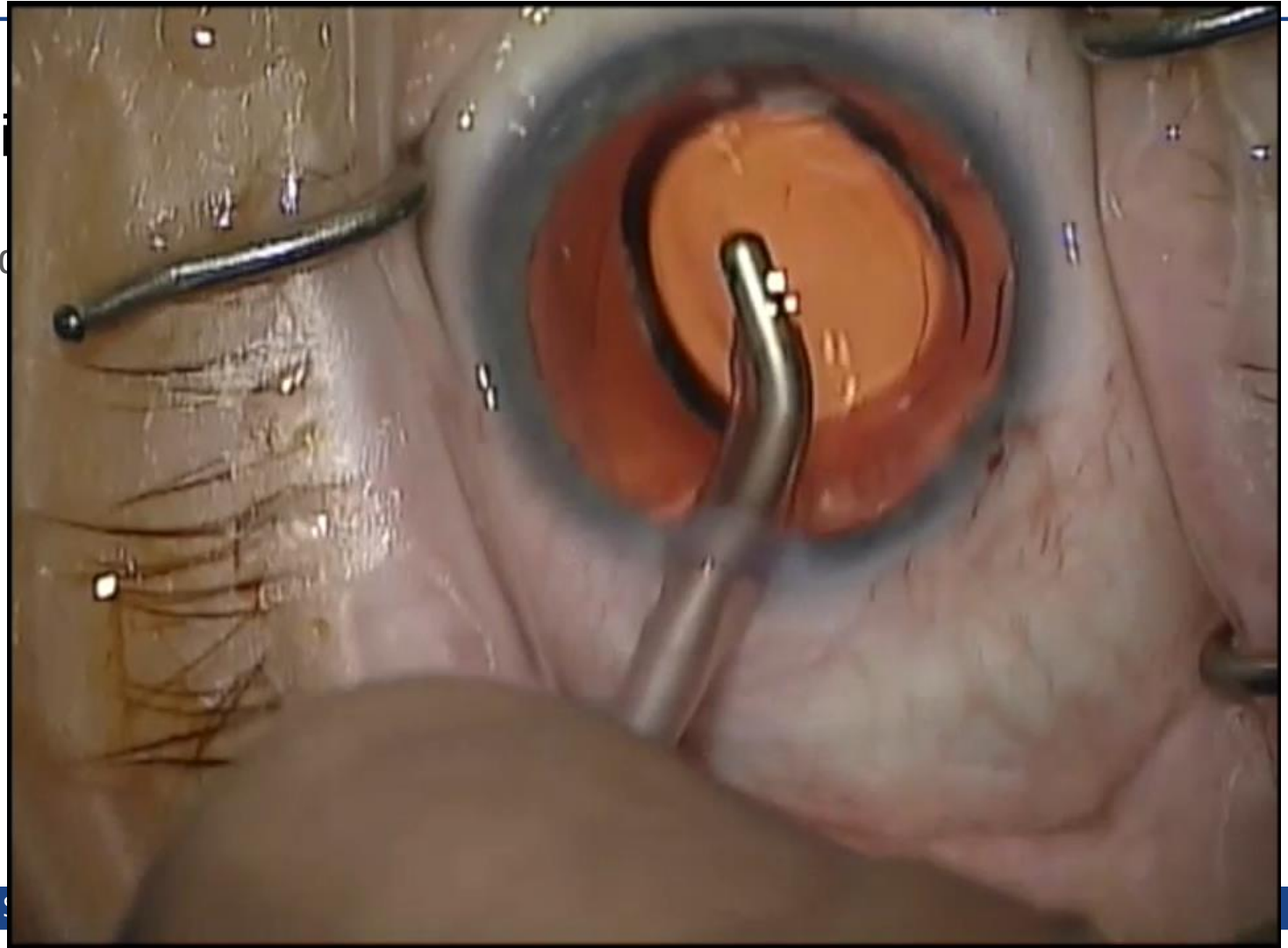
- Vi

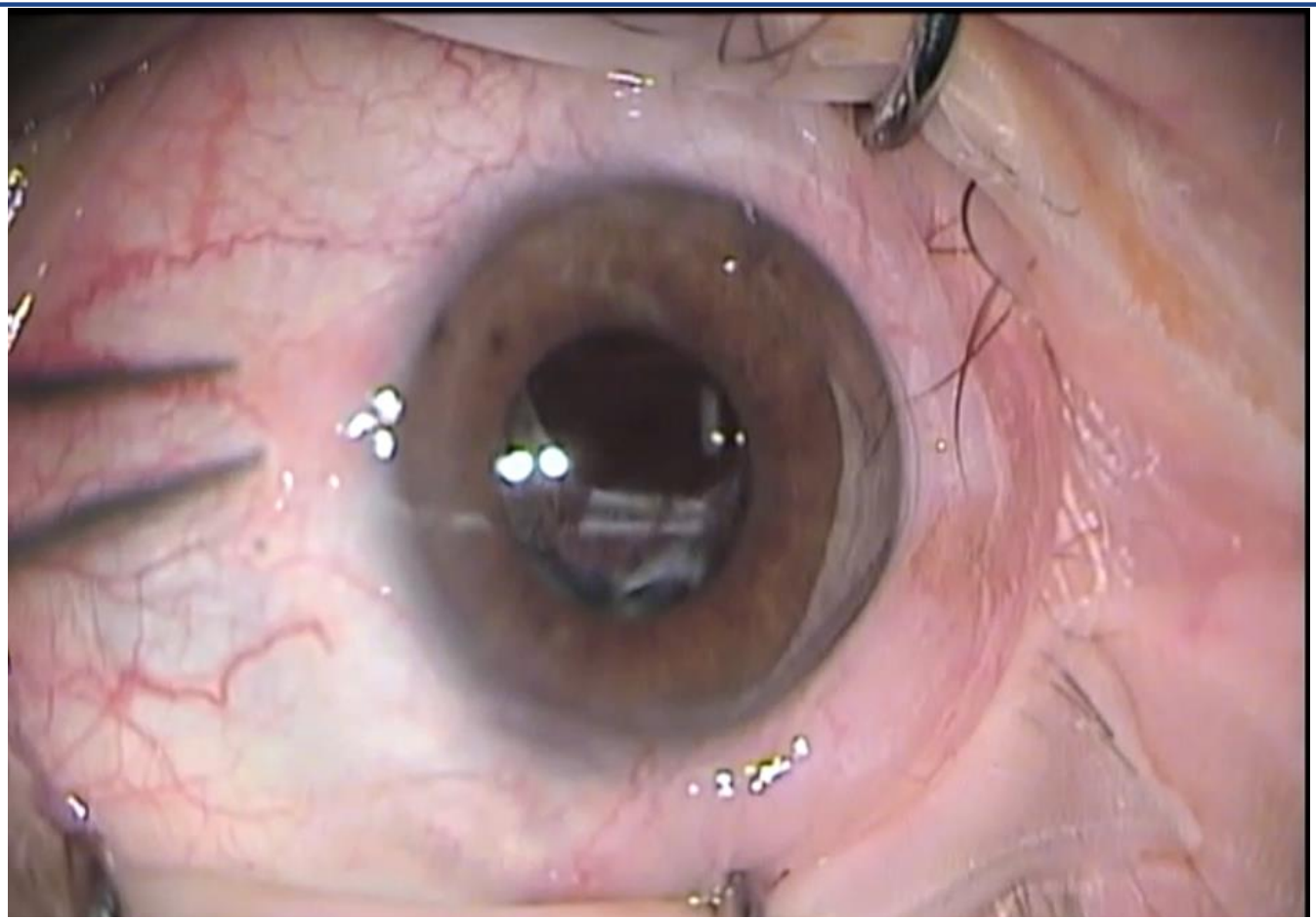


Post-op Long term “Issues”

Post-Op Long Term “Issues”

Lens dislocation

- More common after complex surgery with sulcus positioned lens
- In-the-bag dislocation is more common in PXF or traumatic cataracts
- General rule
  - Stable dislocation with good vision is best left alone
  - Progressive dislocation or symptomatic (diplopia) dislocations need surgical intervention.
  - If dislocated posteriorly or significant vitreous prolapse present, I recommend referral to a retinal specialist.



PXF dislocated IOL repair

A Few Final Thoughts…

- The co-managing optometrist and ophthalmologist must trust and respect each other!
- Open communication is absolutely necessary.
- The ophthalmologist must be comfortable communicating complications and issues they encountered during the surgery.
- The optometrist must be comfortable asking questions about and discussing abnormal post-operative findings with the surgeon and recognize their own comfort level with a given problem.
- There is no room for pride or large egos on either side!
- With a team approach we can achieve the best outcomes possible for our patients.

WOW!

That one is so small it looks like a lure!!!

Yes, this is the smallest fish ever caught!!

Thank You!