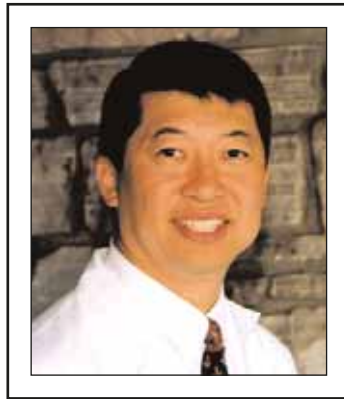


Learning From Refractive Surgeons

Prior to 2004, the distinction between refractive and cataract surgeons was straightforward. Our procedures, reimbursement processes, and patient populations were entirely different. All of this changed with the launch of the Crystalens and Verisyse IOLs in 2004, the Restor and Rezoom IOLs in 2005, and the landmark ruling by the CMS on balance billing for presbyopia-correcting IOLs. Suddenly, a major segment of refractive surgery was intraocular, and nearly everyone needing cataract surgery was a potential refractive patient. Recognizing this paradigm shift, *Cataract & Refractive Surgery Today* held the first and second annual Refractive IOL Symposia in December 2004 and 2005. Most major ophthalmology meetings conduct the cataract and refractive symposia in different rooms or on different days. Our goal was to provide an integrated curriculum in which refractive and cataract specialists could debate and teach each other. We need each other's help.

What does premium refractive IOL surgery entail? Our next two issues attempt to answer this question by presenting highlights from our recent meeting. Because no current IOL design is perfect, we must understand the optical pros and cons of each. If I were a patient, I'd want my surgeon to have experience with every option. Combining different IOLs to achieve complementary advantages is an intriguing idea that needs careful investigation. Our refractive target is no longer -1.00D to plano; we must now hit emmetropia every time. This means performing limbal relaxing incisions for even mild amounts of astigmatism as well as using the latest-generation IOL formulae, personalized A-constants, and noncontact biometry. The IOLMaster measures to fixation, which is critical for myopes with a subtle staphyloma. However, I need immer-



sion ultrasound for the cataracts that are too dense to measure optically. Lest we believe that technology alone ensures emmetropia, Warren Hill, MD, points out in this issue that consistent effective lens position (due to an "all on" capsulorhexis) is equally important. We should consider routine topical NSAIDs to prevent the mild subclinical cystoid macular edema that can mean the difference between J1 and J6 with a multifocal IOL.

This month, we highlight the many practice management issues that refractive IOLs raise for cataract surgeons. Meeting our obligation to ethically inform cataract patients about these new IOL options is an enormous challenge. Are patients being made aware of these lenses by surgeons who do not offer them? Are others feeling pressured to choose the "better" IOL by a financially motivated surgeon? How do we reign in unrealistic expectations? How do we

avoid the frustration of a marathon consultation after which a confused patient is paralyzed with indecision? Effective and efficient communication requires that we understand the mentality of the different refractive populations. In my own practice, I have found that using the questionnaire developed by Steven Dell, MD, writing my own handouts, and using customizable audiovisual aids, such as the Eyemaginations touchscreen system, are indispensable.

Finally, we need to consider practices that our refractive colleagues adopted long ago. How do we set prices and payment policies? Do we offer financing? Is a different level of informed consent needed? We should network with refractive surgeons in advance to plan how a laser enhancement will be provided and priced when needed. In short, we cataract surgeons have a lot to learn from our refractive colleagues. We at *CRSToday* hope this issue provides a start. ■

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