It's Not About Being New, It's About Being Better

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What excites me most about my involvement with new IOL technologies is not that my practice offers the latest lenses, but rather being able to say that we can improve and enhance patients' visual experiences and outcomes. I am, therefore, selective about which new IOLs I offer to my patients, and I choose only IOLs that I feel will provide them with the best opportunity to achieve the vision that they expect after cataract surgery.

Sometimes patients assume that if something is new, it must be better. But as we know from experience, that is not always the case.

THREE DECISION FACTORS

When deciding if an IOL technology is right for my practice, I first look for evidence that the new technology is safe and effective. If the IOL is based on a tried-and-true lens platform, one that has been implanted in millions of eyes, my decision is made easier, based mainly on accepting the new optical properties of the lens.

My second test for adoption of a new lens technology is to ask colleagues who have experience with that lens about patient complaints. In my opinion, a well-informed decision builds not just from published evidence—which can sometimes take many years to come to fruition—but also from user experience. It is valuable to hear from others how their patients have performed with an IOL before I decide to offer it in my practice.

It also comes down to the level of trust one has with the industry. I have worked with some IOL manufacturers who market, sell, and package their products in ways that can be confusing to both surgeons and patients. For me, therefore, trust is key—trust in your industry partner, trust in the research and development teams of that partner, and trust in its marketing team to be honest and responsible.

TRIAL PERIOD

Once an IOL technology checks those three boxes, the next step is to enter into a trial period during which we evaluate postoperative outcomes very carefully. We screen patients thoroughly and evaluate their outcomes even more carefully than we would when using a familiar lens technology.

For example, I have a lot of experience with several trifocal lens technologies, including the RayOne Trifocal (Rayner, Figure 1). In July 2019, I also began implanting the RayOne Trifocal Toric IOL. It is not routine for us to measure postoperative uncorrected and corrected intermediate vision in our trifocal patients, but we did so when we were evaluating the RayOne Trifocal Toric. We wanted to know exactly what the outcomes were in order to help us decide if the lens met our standards as a routine lens of choice.

I also compared results with the RayOne Trifocal Toric IOL with the results that we've had with other trifocal toric IOLs, including the FineVision trifocal toric (PhysIOL)

Courtesy of Rayner

Figure 1. RayOne Trifocal Toric IOL.

and the AT LISA trifocal toric (Carl Zeiss Meditec). What I found I liked about the RayOne Trifocal Toric is that the haptics are particularly rotationally stable.

Patients want good uncorrected vision at all distances. This IOL helps patients to achieve good UCVA with minimal dysphotopsias and other aberrations. Patients rarely have any glare, although some do have more distinct halos. Halos are easier to cope with, however, because they're distinct and patients can separate them from the central image, even during activities such as nighttime driving.

CONCLUSION

New does not always mean better. It is our job as eye care practitioners to evaluate each IOL technology closely before offering it to our patients. We can do this by evaluating the clinical evidence, asking colleagues about their experiences, finding industry partners we can trust, and charting our own early outcomes closely. It is only then that we can know that this new IOL technology will make a positive impact on our patients' overall experiences.