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Amico Yasna Pars

Ophthalmology Newsletter

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XXVII ANNUAL CONGRESS OF THE IRANIAN SOCIETY OF OPHTHALMOLOGY

بیست و هفتمین کنگره سالیانه

انجمن چشم پزشکی ایران

Dear valued partners

This is the last issue of our newsletter before the largest ophthalmology event in Iran, the 27th ANNUAL CONGRESS OF THE IRANIAN SOCIETY OF OPHTHALMOLOGY which will be held on December 4 - 7, 2017 in Razi convention center in Tehran.

The wide variety of topics which will be presented in the congress in various subspecialties illustrates the importance of this congress and how large it is.

Numerous symposiums, Workshops and other side programs such as live surgeries are being run on this event to show the latest advances and achievements in ophthalmology in Iran. The congress also is a good opportunity for Iranian ophthalmologists to exchange their experiences and share their achievements with other ophthalmologists from other countries in the world.

Like last years, Amico Yasna Pars as a gold sponsor, will be present actively in this important event, introducing latest advances in ophthalmic technology. The company also sees this event as an excellent opportunity to welcome honorable ophthalmologists and have a face to face meeting with its valuable customers. .

Special thanks to IRSO for organizing the congress. Here, we invite all the dear participants to visit our booth in the side exhibition and to be sure that they will be warmly welcomed.

Tecnis Symfony Intraocular Lens with a "Sweet Spot" for Tolerance to Postoperative Residual Refractive Errors

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Abstract

Purpose: To investigate the impact of residual astigmatism on visual acuity (VA) after the implantation of a novel extended range of vision (ERV) intraocular lens (IOL) based on the correction of spherical and chromatic aberration. Method: The study enrolled 411 patients bilaterally implanted with the ERV IOL Tecnis Symfony. Visual acuity and subjective refraction were analyzed during the 4- to 6-month follow-up. The sample of eyes was stratified for four groups according to the magnitude of postoperative refractive astigmatism and postoperative spherical equivalent. Results: The astigmatism analysis included 386 eyes of 193 patients with both eyes of each patient within the same cylinder range. Uncorrected VAs for distance, intermediate and near were better in the group of eyes with lower level of postoperative astigmatism, but even in eyes with residual cylinders up to 0.75 D, the loss of VA lines was clinically not relevant. The orientation of astigmatism did not seem to have an impact on the tolerance to the residual cylinder. The SE evaluation included 810 eyes of 405 patients, with both eyes of each patient in the same SE range. Uncorrected VAs for distance, intermediate and near, were very similar in all SE groups. Conclusion: Residual cylinders up to 0.75 D after the implantation of the Tecnis Symfony IOL have a very mild impact on monocular and binocular VA. The Tecnis Symfony IOL shows a good tolerance to unexpected refractive surprises and thus a better "sweet spot".

Keywords

Extended Range of Vision IOL, Astigmatism Tolerance, Refractive Tolerance,Tecnis Symfony

1. Introduction

At present, multifocal intraocular lenses (MF IOLs) appear to provide the mostconsistent and reliable ethod for the surgical correction of presbyopia [1]. However, residual astigmatism is one of the leading causes of dissatisfaction after the implantation of a MF IOL [2]. These IOLs require emmetropia for the achievement of the best visual outcomes, and small amounts of astigmatism may limit visual performance significantly [3]. Thus, astigmatism has to be completely corrected in order to obtain the maximum efficiency of a MF IOL [4]. The rate of enhancement to reduce residual astigmatism after cataract surgery with implantation of a MF IOL ranges from 5.24% to 23.66% depending on the study. Specifically, Gundersen et al. reported a significant rate of retreatments after MF IOL implantation (10.8%) over a sample of 416 eyes, most of which are due to reduced visual acuity (VA) secondary to residual astigmatism. These authors found no statistically significant differences in the impact of residual astigmatism on the visual outcome between different traditional MF IOL models [5]. Femtosecond laser-assisted procedures have been proposed as a valid alternative for correcting residual refractive errors after cataract surgery [6] [7]. However, the well-known potential complications of corneal refractive procedures, including the induction of higher-order aberrations (HOAs), and the secondary

degradation of the retinal image may also lead to dissatisfaction. Current research is aimed at developing optical designs with a higher tolerance to postoperative defocus. This paper reports our experience about the impact of residual astigmatism on VA after the implantation of a novel extended range of vision (ERV) IOL based on the correction of spherical and chromatic aberration.

2. Patients and Methods

A prospective international multicenter study, the CONCERTO study, was designed to evaluate the clinical outcomes obtained after the implantation of the Tecnis Symfony ZRX00 ERV IOL (Abbott Medical Optics, Santa Ana, USA). The Tecnis Symfony IOL has an achromatic diffractive pattern that elongates the range of vision of the eye and compensates for the chromatic and spherical aberration of the cornea. Specifically, the lens has a biconvex wavefront-designed anterior aspheric surface and a posterior achromatic diffractive surface. The total diameter of the IOL is 13 mm and the optic zone diameter is 6.0 mm. It is made of a UV-blocking hydrophobic acrylic material, with a refractive index of 1.47 at 35˚C. This research included patients who had undergone cataract surgery or clear lens extraction with bilateral implantation of the mentioned ERV IOL. Exclusion criteria included previous ocular surgery, chronic or recurrent uveitis, acute ocular disease or external/internal infection, diabetes with retinal changes, glaucoma or intraocular ressure (IOP) equal or higher than 24 mmHg, pseudoexfoliation syndrome, pathological miosis, keratoconus, and corneal endothelial dystrophy. All patients were informed about the study and provided informed consent to undergo the clinical examinations in accordance with the tenets of the Declaration of Helsinki. The last preoperative examination of the patients included measurement of monocular and binocular uncorrected distance (UDVA), intermediate (UIVA), and near visual acuity (UNVA), monocular and binocular corrected distance visual acuity (CDVA), distance-corrected intermediate (DCIVA) and distancecorrected near visual acuity (DCNVA), optical biometry, manifest refraction, biomicroscopy, Goldmann applanation tonometry, and fundoscopy. Postoperatively, all patients were evaluated during a 4 - 6-months follow-up. Monocular and binocular UDVA and CDVA, and binocular UIVA and UNVA, as well as subjective refraction were assessed at the end of the follow-up. For the analyses, the sample of eyes was subdivided into four main groups according to the level of postoperative refractive astigmatism: less than 0.25 D, 0.25 to <0.5 D, 0.5 to <0.75 D cylinder, and more than 0.75 D. Another subdivision was also performed considering the postoperative spherical equivalent (SE): within ±0.25 D, within ±0.50 D, within ±0.75 D, within ±1.00 D, and within ±2.00 D. In order to evaluate the binocular visual acuity measurements, patients were only included in this analysis if both eyes were in the same postoperative cylinder range or within the same range of postoperative spherical equivalent, respectively. SPSS statistics software package version 15.0 for Windows (IBM, Armonk, NY, USA) was used for the analyses. Mean values of binocular UDVA, UIVA and UNVA were obtained with their corresponding standard deviation values. Differences between the impacts of the astigmatism orientation were analysed with the Mann-Whitney test.

3. Results

Postoperative cylinder

A total of 386 eyes of 193 patients were included in this evaluation with both eyes of each patient within the same cylinder range. A total of 184 eyes of 92 patients (47.67% of the sample) showed a postoperative astigmatism equal or higher than 0.50 D, while 202 eyes of 101 patients (52.33% of the sample) had a

Discussion

postoperative cylinder of less than 0.50 D. The demographic data of the groups are shown in Table 1. There were no statistically significant differences regarding demographic data between groups, except for the proportion of females and males. Table 2 shows the monocular and binocular UDVA and CDVA outcomes, as well as binocular UIVA and UNVA data for the four subgroups stratified according to the residual postoperative astigmatism. As shown, uncorrected Vas for distance, intermediate and near were better in the group of eyes with lower level of postoperative astigmatism (Table 2).

However, even in the group of eyes with residual cylinders up to 0.75 D, the loss of VA lines was not clinically relevant. Specifically, binocular UDVA only suffered a slight reduction of 1 line for a postoperative astigmatism up to 0.75 D. Likewise, binocular UIVA and UNVA changed from 0.89 to 0.81 and from 0.72 to 0.70 with surgery, respectively. The orientation of astigmatism did not seem to have an impact on the tolerance to the residual cylinder, as shown in Figure 1. No significant differences in binocular UDVA, UIVA and UNVA were found among eyes with with-the-rule (WTR), against-the-rule (ATR) and oblique (OBL) astigmatism ($p \geq 0.143$). In any case, it should be mentioned that significant differences were found in the magnitude of sphere and cylinder among eyes with with-the-rule (WTR), against-the-rule (ATR) and oblique (OBL) astigmatism (Figure 2). Specifically, significantly lower magnitude of cylinder and significantly higher magnitude of sphere were found in the groups of eyes with ATR astigmatism compared to those with WTR and OBL astigmatisms ($p < 0.001$). Postoperative spherical equivalent

Besides the impact of residual cylinder, the tolerance of the Tecnis Symfony IOL to the level of postoperative SE was also evaluated. In this case, the evaluated sample included a total of 810 eyes of 405 patients, with both eyes of each patient in the same SE range. The demographic data of the groups are shown in Table 3. There were no statistically significant differences regarding demographic data between groups.

Cylinder range (D)	UDVA OD	UDVA OS	UDVA OU	CDVA OD	CDVA OS	CDVA OU	UIVA OU	UNVA OU	N
0 to <0.25	0.90 ± 0.27	0.89 ± 0.20	1.02 ± 0.21	1.02 ± 0.19	1.01 ± 0.15	1.09 ± 0.20	0.89 ± 0.28	0.72 ± 0.24	91
0.25 to <0.5	0.82 ± 0.22	0.85 ± 0.24	1.00 ± 0.23	0.99 ± 0.12	0.99 ± 0.12	1.18 ± 0.31	0.68 ± 0.28	0.54 ± 0.18	10
0.5 to <0.75	0.78 ± 0.21	0.83 ± 0.20	0.90 ± 0.17	0.97 ± 0.17	0.96 ± 0.17	1.01 ± 0.18	0.81 ± 0.28	0.70 ± 0.24	42
0.75 and more	0.74 ± 0.23	0.72 ± 0.23	0.84 ± 0.20	0.95 ± 0.15	0.94 ± 0.17	0.99 ± 0.16	0.72 ± 0.24	0.63 ± 0.24	50

Table 2. Influence of the residual cylinder on decimal visual acuity (4 - 6 months, CONCERTO Study). Abbreviations: UDVA (Uncorrected Distance Visual Acuity); CDVA (Corrected Distance Visual Acuity); UIVA (Uncorrected Intermediate Visual cuity); UNVA (Uncorrected Near Visual Acuity); OD (right eye); OS (left eye).

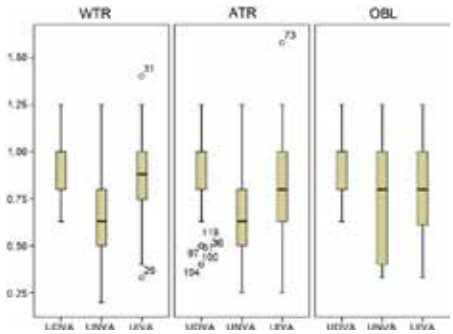

Figure 1. Distribution of the binocular visual outcome according to The orientationof astigmatism (WTR: with the rule, ATR: against the rule, OBL: oblique).

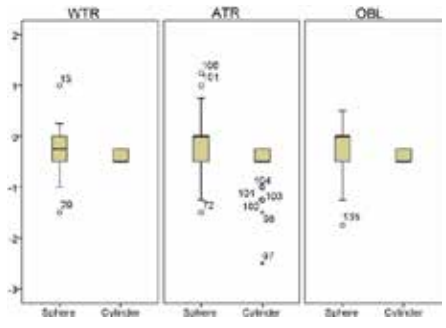

Figure 2. Magnitude of sphere and cylinder in eyes with different orientation of astigmatism (WTR: with the rule, ATR: against the rule, OBL: oblique).

Table 4 shows the monocular and binocular UDVA and CDVA outcomes, as well as binocular UIVA and UNVA data for the five subgroups stratified according to the residual postoperative SE. Uncorrected distance, intermediate and

near VAs were very similar in all SE groups (Table 4). Binocular UDVA did not change significantly and only showed a very slight difference of 0.05 between a postoperative SE of ±0.25 and ±2.0 D. Likewise, the levels of uncorrected binocular intermediate and near VAs improved slightly for higher magnitudes of residual SE.

Table 1. Demographic data in the 4 groups stratified for postoperative residual cylinder.

	Postoperative residual cylinder			
	0 to <0.25 D	0.25 to <0.5 D	0.5 to <0.75 D	≥0.75 D
No. of patients	91	10	42	50
Age (mean ± SD)	63.3 ± 9.1	65.2 ± 10.0	63.1 ± 12.03	69.88 ± 10.8
Gender female/male (%)	68.1/31.9	70.0/30.0	59.5/40.5	46.0/54.0

Table 3. Demographic data in the 4 groups stratified for postoperative spherical equivalent.

	Postoperative spherical equivalent				
	within ±0.25	within ±0.5	within ±0.75	within ±1.0	within ±2.0
No. of patients	134	229	307	359	405
Age (mean ± SD)	63.1 ± 11.2	65.5 ± 10.9	65.3 ± 10.7	64.6 ± 10.9	65.5 ± 10.9
Gender: female/male (%)	61.9/38.1	57.2/42.8	58.6/41.1	59.3/40.7	59.8/40.26

Table 4. Influence of residual spherical equivalent on visual acuity (4 - 6 months, CONCERTO Study). Abbreviations: SE (Spherical Equivalent); UDVA (Uncorrected Distance Visual Acuity); CDVA (Corrected Distance Visual Acuity); UIVA (Uncorrected Intermediate Visual Acuity); UNVA (Uncorrected Near Visual Acuity); OD (right eye); OS (left eye).

SE range (D)	UDVA OD	UDVA OS	UDVA OU	CDVA OD	CDVA OS	CDVA OU	UIVA OU	UNVA OU	N
Within ±0.25	0.92 ± 0.17	0.92 ± 0.19	1.00 ± 0.15	0.98 ± 0.15	0.99 ± 0.18	1.06 ± 0.18	0.77 ± 0.26	0.62 ± 0.22	134
Within ±0.50	0.90 ± 0.19	0.89 ± 0.19	0.99 ± 0.17	0.98 ± 0.15	0.99 ± 0.17	1.06 ± 0.18	0.79 ± 0.26	0.63 ± 0.22	229
Within ±0.75	0.87 ± 0.20	0.87 ± 0.19	0.98 ± 0.18	0.99 ± 0.15	0.99 ± 0.16	1.06 ± 0.18	0.81 ± 0.27	0.65 ± 0.23	307
Within ±1.00	0.84 ± 0.22	0.85 ± 0.21	0.96 ± 0.19	0.99 ± 0.16	0.98 ± 0.16	1.06 ± 0.18	0.80 ± 0.27	0.67 ± 0.24	359
Within ±2.00	0.82 ± 0.23	0.84 ± 0.22	0.95 ± 0.20	0.98 ± 0.16	0.98 ± 0.16	1.05 ± 0.18	0.81 ± 0.27	0.68 ± 0.25	405

4. Discussion

This observational type of study enrolled patients with the need or desire of lens exchange. In order to be able to evaluate the impact of the IOL implantation on residual astigmatism or spherical equivalent, the exclusion criteria were chosen in a way that other ocular pathologies don't blur the refractive results. In the CONCERTO study, the Tecnis Symfony IOL provided a homogeneous and excellent visual restoration across all distances after cataract surgery or clear lens exchange, with minimal levels of disturbing photic phenomena [8]. Previous theoretical and in -vitro studies have demonstrated that the combination of the compensation for chromatic aberration, primary spherical aberration and unique echellette design results in an increased ability to provide an extended range of vision [9] [10] [11]. Also, the light distribution of the

Tecnis Symfony IOL between its best vision foci has been demonstrated to be more homogeneous and less vergence dependent under dim conditions compared to multifocal IOLs [12]. This special optical design allows excellent optical and visual outcomes for far and intermediate distances, and a functional range of VA for near. According to our results, residual cylinders up to 0.75 D after the implantation of the Tecnis Symfony IOL have a very mild and clinically insignificant impact on monocular and binocular UDVA. Likewise, binocular UIVA and UNVA are not significantly affected in this situation. The orientation of the residual astigmatism does not seem to have either a significant impact on the visual outcome achieved with the Tecnis Symfony IOL, with similar UDVA, UIVA and UNVA in eyes with WTR, ATR and OBL astigmatisms. Regarding the postoperative SE, the Tecnis Symfony IOL shows a good tolerance to unexpected refractive surprises and thus a better "sweet spot".

5. Conclusion

In summary, the Tecnis Symfony IOL is a new promising alternative to provide an effective and continuous range of vision from far to near distances after cataract surgery or refractive lens exchange. This novel IOL provides an added value by the good tolerance to postoperative residual refractive errors, which is a key factor for ensuring patient satisfaction.

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ENSURE TORIC IOLs' STABILITY

Pay close attention to wound construction and sealing.

BY DANIEL H. CHANG, MD

The rotational stability of a toric IOL is crucial to a successful outcome. For the best visual acuity results, the IOL should be placed and remain within 5° of the axis of astigmatism. Postoperative IOL misalignment is commonly due to errors in preoperative biometry and marking—important topics that are not addressed in this article. Assuming the surgeon places the IOL correctly, why is there any rotation at all?

The exact mechanism for toric lens rotation is not well understood. The lens is confined within the bag where there is no bulk fluid flow or other internal force vectors after surgery. Rotation is therefore likely due to external forces applied to the eye. If an eye were hypotonous, forceful blinking, eye rubbing, or the pressure of a dropper bottle could transmit a force to the IOL. Compressing a hypotonous eye is therefore likely the primary mechanism for toric IOL rotation. Gross deformation of the globe could cause a shift in the IOL's position.

After implanting more than 300 Tecnis Toric IOLs (Abbott), I have only had to reposition one. This is due in part to the excellent stability of the lens itself. In clinical trials, it had a mean axial change of just 2.74° between baseline and 6 months. More than 90% of the lenses rotated 5° or less between visits 3 months apart (Figure). Good surgical technique is key. Here are four steps for ensuring that a toric IOL is properly aligned for optimal results.

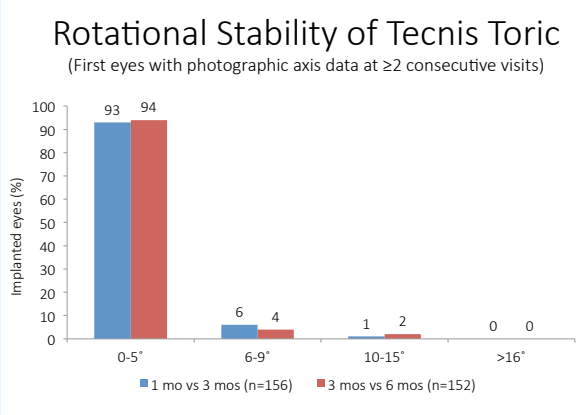

Figure. Excellent stability has been reported for the Tecnis Toric IOL. Surgeons can further maximize stability by following the techniques described in this article.

STEP No. 1 BE METICULOUS ABOUT WOUND CONSTRUCTION

Whether using a femtosecond laser or a blade, construct a triplanar incision that will seal well at the end of the case. It should be nearly square and long enough for good wound closure.

STEP No. 2 CREATE A WELL-CENTERED CAPSULOTOMY

A full 360° of capsular overlap may help to limit asymmetric capsular forces on the IOL postoperatively.

STEP No. 3 POSITION THE IOL CORRECTLY IN A CLEAN CAPSULE

IOL implantation should be done with a cohesive viscoelastic for easy and complete removal at the end of the case. As the lens unfolds, I rotate it in the bag several times and perform aspiration behind the IOL. This process helps to clear out retained viscoelastic and cortical debris. It also ensures that the haptics are fully deployed into the capsular fornix. Once the haptics have unfolded completely, I center the IOL by having the patient fixate on a coaxial light source. Then, I align the marks on the IOL with the corneal axial marks on the steep meridian. The IOL need not align perfectly with these axial marks. As long as it is parallel to the marks, it is more important to center the IOL well.

STEP No. 4 ENSURE A TIGHTLY SEALED WOUND

I hydrate the wound to seal it and bring the eye to physiologic pressure, while being careful not to under- or hyperinflate it. With the chamber stable, I can fine-tune the lens' position before finally rehydrating and

Discussion

checking the wounds and the IOL's position one last time. When checking the wound, I dry it to find slow leaks and press on the globe to simulate an eye rub. When in doubt, I suture the wound or consider a sealant.

CONCLUSION

Postoperatively, I instruct patients not to rub their eyes. I try to minimize the dosing regimen of postoperative drops with combination products or dropless surgery. This reduces the chance that patients will rub their eyes or poke them with the bottle, which I suspect is a common occurrence.

With these steps (see *Watch It Now*), surgeons can be confident that their toric IOLs will remain stable to successfully correct astigmatism in refractive cataract patients. ■

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- financial disclosure: consultant to Abbott

Events

A one-day seminar was held in Helal Ahmar Hospital on premium IOLs in cataract surgery

Helal Ahmar is one of the most prestigious and active hospitals in Tehran. The center founded in 1999 and today with 70 active ophthalmologists and more than 15000 surgeries per year is one of the biggest ophthalmology centers in Iran. On October, 19th, 2017, a meeting has been organized at Helal Iran Pharmaceutical and Medical Complex on different types of Premium IOLs and their technical specifications. The latest improvements and achievements in ophthalmic products have been reviewed during this one-day seminar. Among many products, Abbott's Tecnis Symfony, the premium intra ocular lens for correcting presbyopia and Tecnis Toric were two of main titles which were reviewed by participants. Amico Yasna Pars, the exclusive distributor for Abbott in Iran actively participated the side events.

Upcomming Events

11-14 November 2017	1-2 December 2017	1-2 December 2017	4-7 December 2017
American Academy Of Ophthalmology 2017 (AAO 2017)	UCSF (The University of California, San Francisco School of Medicine) Ophthalmology Update 2017	47th European Contact Lens Society of Ophthalmologists Congress 2017 (ECLSO 2017)	XXVII Annual Congress of the Iranian Society of Ophthalmology
New Orleans	San Francisco	London	Tehran

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