SO, YOU’VE GOT A CATARACT?

WHAT YOU NEED TO KNOW ABOUT CATARACT SURGERY:
MODERN EYE SURGERY, ADVANCED IOLS & CHOOSING YOUR SURGEON

DAVID RICHARDSON, MD
SO, YOU’VE GOT A CATARACT?

(What You Need to Know About Cataract Surgery: A Patient’s Guide to Modern Eye Surgery, Advanced Intraocular Lenses & Choosing Your Surgeon)

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ABOUT THE AUTHOR

Dr. David Richardson, M.D., is a graduate of both the University of Southern California and Harvard Medical School. He has received multiple national awards and scholarships, including the Phi Beta Kappa Scholarship and the Harvard National Scholarship. After medical school, he completed his residency in ophthalmology at the Doheny Eye Institute, one of the top eye surgery programs in the United States. Today, he is in private practice with offices in Pasadena and San Gabriel, California.

An accomplished board-certified surgeon, Dr. Richardson has performed thousands of advanced cataract procedures with excellent results. In a survey of physicians, he was voted a Pasadena Magazine “Top Doc” in 2008, 2009, 2010, 2011, and 2012 as well as a Los Angeles Magazine “Super Doctor” in 2010, 2011, and 2012. He has also been the recipient of the Patient’s Choice award as well as the Most Compassionate Doctor award.

In addition to authoring this book, Dr. Richardson shares his thoughts about advances in cataract surgery at www.About-Eyes.com and glaucoma at www.New-Glaucoma-Treatments.com. He can be reached through his web site at www.David-Richardson-MD.com or by calling his office at (626) 289-7856.
This book is dedicated to my patients. Your questions inspired me to write down many pearls from our conversations about cataracts and cataract surgery. I thank you for teaching me how to listen, as well as (I hope) communicate the clinical, surgical, and technical elements of cataract surgery in a manner that makes sense to someone who has not attended medical school. You also deserve my thanks for continuously reminding me of the wonder of modern cataract surgery, as well as the miracle of sight. It is truly humbling to realize that I have been chosen by so many wonderful people to share in their joy as they experienced the renewal of vision generally associated with cataract surgery.
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INTRODUCTION

It’s a curious thing. People with cataracts often have very poor vision, making it difficult for them to read. And yet, their physicians typically ask them to sift through stacks of educational pamphlets and paperwork on cataracts. The documents are often single-spaced with small print and thin margins — in short, a nightmare for someone with cataracts. What’s more, the information is oozing with hard-to-understand medical jargon and procedural terminology. Needless to say, it is a frustrating experience.

I really want my cataract patients to have an entirely different experience. This is why I went to work on So, You’ve Got a Cataract?

This is a book about cataracts for people with cataracts. My goal is to provide the information you need to learn about your eye’s condition and to make good, safe decisions about treatment.

The book covers, in a language that anyone can understand, basic information about how the eye works and what is useful to know about a cataract. If you are considering modern cataract surgery, you will find most of what you need to know within the pages of this book. It will also help you prepare for surgery. You’ll learn what happens during the actual procedure and what to expect afterwards.

The larger page size and Kindle eBook format were specifically chosen for this project as they allow for enlarging the text size making it easier for those with poor vision to read.
But please note: throughout this book I offer my personal professional opinion. The techniques described are based on the way I perform surgery. Other cataract surgeons will likely have their own methods and preferences.

In addition to this book, I have also produced a companion audio CD for those whose vision is too poor to read even large print. Copies of this CD can be purchased online at www.amazon.com/author/davidrichardson

Okay, then. Let’s get started…
ABOUT CATARACTS

HOW THE EYE WORKS

Let’s start with a review of how the eye works. It’s helpful to think of the eye as a video camera hooked up to a TV. A video camera has a lens to focus an image, film or a sensor to capture or record the image, and a cable to transmit the image to a TV.

Your eye works in a similar way. It has two surfaces that focus an image: the cornea and the natural lens of the eye. The cornea, which is a clear, curved surface, bends light passing through the eye; the lens fine-tunes the light before passing it onto the retina, located at the back of the eye. The retina records light, much like the film or sensor in a camera, and then converts it into an electrical signal. From here, the signal is transmitted to your brain through the optic nerve, which is similar to the cable that connects a video camera to a TV. The brain then processes the signal to let you see the image.
WHAT IS A CATARACT?

Although the cornea is responsible for most of the focusing (refractive) power of the eye, the lens is critical for crisp, clear vision. Without it, we would need glasses as thick as the bottom of a Coke® bottle to see the world clearly.

For most of our lives, the natural lens is flexible and clear — allowing us to focus on objects both far and near. Around age 45, however, the lens becomes less flexible and loses its ability to change focus. It becomes difficult to see objects up close. In order to focus, you begin holding reading materials further away. This condition is called presbyopia, or “aging eyes.” Although annoying, reading glasses or bifocals often help.

As time passes, the lens continues to lose its flexibility. Eventually it hardens and becomes cloudy and discolored. Just as a piece of plexiglass exposed to sunlight will slowly turn grey, then yellow, then brown, a lens loses clarity and becomes discolored. A cloudy, discolored lens interferes with light passing through it, causing blurry vision. When the clouding blocks enough light and impairs vision to the point where glasses won’t even help, the
lens is generally considered to have become a cataract.

**Can you avoid getting a cataract?**

I often tell my patients that I hope to be fortunate enough to get cataracts. Why? Because cataracts are a natural part of the aging process. As many as 70% of those over the age of 75 have a cataract. In other words, if I get a cataract, it means that I’ve lived a long life.

So, just because we are all destined to get them, can we postpone them? As a matter of fact, you might already be doing the one thing that can possibly delay the development of a cataract: wearing sunglasses with ultraviolet (UV) protection when outdoors. If you are not doing this, it is never too late to start.

You see, ultraviolet light from sun exposure affects the proteins in our bodies and causes oxidative damage or free radical damage (from high-energy particles that damage almost anything they come into contact with). When ultraviolet light passes through the eye’s natural lens, some of it is absorbed by the eye, resulting in free radical damage to the lens. Over time, this damage builds up and the lens becomes cloudy. The best way to postpone damage from UV light, and perhaps delay forming a cataract, is to wear sunglasses that block it.

Smoking and excessive alcohol consumption are among other causes of free radical damage.
Since free radicals produce oxidative damage, you may think that antioxidants should have a protective effect. This may very well be the case. However, to date no well-designed clinical trial has demonstrated that antioxidant therapy can delay the onset of cataracts. That being said, I still recommend over-the-counter antioxidant multivitamins to my patients. There is very little risk to taking them and the possible benefit is compelling. However, I also warn my patients against paying large sums of money to purchase the multivitamin “cataract cure,” which is often advertised in magazines. There is absolutely no evidence that these “special” vitamins do anything other than lighten your wallet.

Is age the only thing that causes cataract?

Though aging is the most common cause of cataracts, a host of other things can cause cataracts. I already mentioned sun exposure. Cataracts may also be congenital (present at birth), metabolic (caused by too much or too little of one of the chemicals produced in your body), toxic (from medications or other external chemicals), nutritional (from a lack of vitamins or minerals), postsurgical (as a result of prior eye surgery), traumatic (from a blunt or sharp injury), or secondary (related to other diseases of the body, radiation, or any other cause that is not age-related). In short, there are a lot of things that can damage the eye and cause the formation of a cataract.

To summarize, if you are not getting older, are never exposed to the sun or any other source of oxidative damage, have no eye disease, and enjoy perfect nutrition, then you might be able to avoid cataracts. For the rest of us who are mere mortals, it’s a foregone conclusion that life leads to cataracts.
CATARACT SYMPTOMS

Often cataracts develop slowly. People typically don’t realize their vision has deteriorated until the cataracts interfere with something they need or like to do. Some people start to have trouble reading or completing crossword puzzles. Others begin to have difficulty with such things as driving, watching TV, or playing golf.

Because the change in vision is so gradual, many people are convinced it is the world, and not their vision, that has changed. I often hear patients say, “Those charts in the DMV are smaller than the last time I got my license,” or “The newspapers must be trying to save money on ink, because it’s not as dark as it used to be.” When I hear these things, I pretty much know I’m about to diagnose a cataract.

Typical symptoms of cataracts include:

- Glare or halos around lights at night
- Change in vibrancy of colors or yellowing of colors
- Cloudy vision
- Blurry vision
Some people say their vision with cataracts is like looking through a dirty windshield.

**WHEN TO CONSIDER TREATMENT**

When cataracts interfere with your normal activities, such as reading a newspaper or driving a car, and your vision cannot be corrected with glasses or contact lenses, it’s time to consider treatment, which means cataract surgery. Fortunately, many recent advances have made cataract surgery one of the most effective and safe surgical procedures.

Unlike years ago, you no longer need to wait until the cataract is “ripe,” or so advanced that your vision is seriously impaired. If cataracts affect your daily activities, and your eye surgeon feels you have a significant cataract, then most insurance companies, including Medicare, will cover the cost of the procedure.

**MYTHS ABOUT CATARACT TREATMENT**

There is an incredible amount of misinformation about the treatment
of cataracts. The most common myths are that you can make cataracts disappear by eating certain foods, taking various supplements, or using eye drops.

The truth is, cataracts are a normal part of aging. As with other aging changes, there is no proven way to reverse the hands of time. Let me be clear: There are no drops, vitamins, herbs, or beyond-the-border remedies that will make your cataract disappear.

You may be able to relieve some of the symptoms of an early cataract with glasses or contact lenses. But eventually, as the cataract progresses, even these will fail to help your vision.

If decreased vision interferes with your everyday activities, then cataract surgery may be worth considering. The only other option is to limit your activities.

Cataract surgery is the most common surgical procedure in the United States for people 65 years or older. Each year nearly 3 million Americans undergo the procedure. It involves removing an aging, cloudy eye lens and replacing it with an artificial one. Once done, cataract surgery can dramatically improve a person’s quality of life.
“A friend of mine said that cataract surgery in today’s world is a piece of cake. I didn’t know whether he was right or not. Having experienced it yesterday, I would say he was correct. It was a piece of cake!”

- Ken Obst
Cataract Surgery Patient
WHAT YOU NEED TO KNOW ABOUT CATARACT SURGERY

MODERN CATARACT SURGERY

So, let’s talk about modern cataract surgery. It safely and painlessly treats cataracts and is usually very successful — more than 90% of patients experience improved vision after their surgery. It’s normally done as an outpatient procedure that uses ultrasound technology. Rarely does it require general anesthesia. Instead, surgeons typically use a local anesthetic to numb the eye as well as a sedative to relieve anxiety.

During modern cataract surgery, the surgeon makes a micro-incision at the edge of the cornea. These incisions used to be quite large (at least by today’s standards) and required many stitches. In fact, years ago people had to stay in bed for weeks with sandbags on their eyes in order to keep these large incisions from opening up. Today, however, the incision is really tiny, often less than 3 millimeters wide, which is about the size of an average pen tip. The incision is so small that stitches are often unnecessary.

The surgeon typically removes the cloudy lens through this tiny incision with an ultrasound-based technique called phacoemulsification.
The process begins by injecting a clear gel, called a viscoelastic agent, into the eye. This gel protects the cornea from the ultrasound energy and keeps your eye pressurized during surgery.

For many surgeons, the most challenging part of cataract surgery comes next: creating a small round opening (called a capsulorrhexis) in the bag-like lens capsule, a membrane that surrounds the cataract and holds it in place. As membranes go, this one is pretty thin: somewhere between 5 and 15 millionths of a meter thick (about the size of a tiny speck of dust). Hard to imagine? Well, it’s hard to see. Not only is the capsule at the limits of what the human eye can make out, it’s also transparent!

Amazingly, most experienced cataract surgeons have no problems creating an opening in this delicate, transparent membrane. Occasionally, however, the capsule does tear. If this happens, all is not lost. Surgery may take longer to complete, but good results are still possible. In part due to this risk, some surgeons are now using a laser (called a Femto laser) to create this opening in the capsule (more on this later).

The surgeon will then insert a very tiny ultrasound probe through
the opening in the capsule. The probe emits ultrasound waves that break the cataract into tiny pieces. The pieces are suctioned out (aspirated) through the small opening, leaving behind an empty lens capsule.

Next follows the insertion of the artificial lens implant — known as an intraocular lens (IOL) — into the empty capsule. The surgeon adds more protective gel to the eye and then folds and slips the implant through the incision. The IOL unfolds in the capsule to fill the space where the old lens (the cataract) used to be. After the implant is in place, the surgeon removes the protective gel and, if necessary, closes the incision with a stitch.

The entire procedure often takes less than half an hour.

**A word about no-stitch surgery**

Many cataract surgeons have started advertising “sutureless” or “no-stitch” cataract surgery. This obviously implies that surgery with stitches is somehow inferior to surgery without stitches. It is important to note that stitches can be a good idea as they may reduce the risk of infection (something we’ll discuss in more detail in the chapter covering cataract surgery risks). Don’t be drawn in by glitzy advertisements. The most important thing is to get the best possible surgery. Not everyone is a good candidate for suture-less cataract surgery.
“He (Dr. David Richardson) did a surgery on my right eye about two months ago, removing a cataract, and I’m absolutely amazed at the improvement in my vision. I went clear down to 20/25”

- John
Cataract Surgery Patient
Cataract surgery is very quick, often requiring less than half an hour to complete. However, for the surgery to be successful, you will have to take the time needed to prepare your eye for the procedure.

Every surgeon has a written list of instructions for patients to follow before surgery. Your list will most likely include many of the items below.

**THE WEEKS BEFORE SURGERY**

**Get pre-op medical clearance** – Your internist or family physician will need to clear you for surgery. You may need a blood test, EKG, and physical exam. These assessments typically must be completed at least one week — but not more than one month — prior to surgery. Because modern cataract surgery is usually performed with
local anesthetic and light intravenous (IV) sedation, medical clearance is usually granted to most patients, unless a patient has significant heart or lung disease.

**Schedule a pre-operative (pre-op) assessment** – Before the surgery, you’ll have a pre-op visit with your surgeon. The purpose of this visit is to take your eye measurements in order to determine the proper strength of the artificial IOL implant. Plan on spending some time reviewing and completing paperwork. It seems that every year the government adds more paperwork requirements, so be prepared. The pre-op visit is also a perfect opportunity to discuss any of your concerns. Don’t be afraid to ask questions.

**Stop wearing contact lenses** – Are you a contact lens wearer? If so, at least two weeks before your pre-op visit, stop wearing the contact lens in the eye that will be undergoing surgery. Why? Because contact lenses can distort the surface of your cornea and affect measurements that your surgeon needs to take for selecting the best IOL for your surgery.

**Start using artificial tears or dietary supplements** – Your surgeon may recommend that you start using artificial tears at least 4 times a day prior to the pre-op visit. Artificial tears help to prepare the eye for the pre-op measurements. Other things that can help prepare the eye include taking **omega-3 fatty acid supplements**, such as fish oil and flaxseed oil by mouth.
Start using eye drops – During your pre-op visit, you will be given prescriptions and instructions for eye drops that you’ll need to start using prior to surgery. These drops provide protection from both infection and inflammation.

Be ready for more paperwork – Thanks to the good intentions of a new federal government rule, you may need to go to the surgical center to fill out some paperwork at least one day before your surgery.

THE NIGHT BEFORE SURGERY

You may be instructed not to eat or drink anything after midnight before your surgery. Normally, you’re allowed very small sips of water for taking your medications the morning of your procedure.

A NOTE REGARDING THE “LINE-UP,” OR THE SURGERY SCHEDULE

All surgeons have their own method of determining the line-up. At my surgery center, I do not determine the line-up until I have completed all of the pre-op visits for everyone scheduled on a given day. Then I review all of their charts and measurements. Patients who have serious health issues — for example, diabetes — might be scheduled earlier in the day than someone who is otherwise healthy. Therefore, it’s common for patients not to know the time of their procedure until 2 or 3 days before the surgery.
“Unfortunately, one day, while working, I suddenly lost vision in my left eye. Never experiencing this happening to me before, I immediately went to Huntington Memorial Hospital, to the emergency room. They had quickly diagnosed me with cataracts in my left eye. I was promptly dispatched to a number of other doctors, who ultimately referred me to Dr. Richardson to have the cataract surgery performed.

In the beginning, I was very concerned about what happened. But after meeting with several of the doctors, and especially after linking up with Dr. Richardson and his staff, I was promptly put to ease. I actually had gone through the surgery with Dr. Richardson, and within the next day, actually, the day of the surgery, having the lens replaced, I could then see 100 percent again...”

- Robert Morris
Cataract Surgery Patient

It is unusual for cataracts to cause a sudden loss of vision. What is common, however, is for someone to be unaware that their vision has changed. If a cataract is developing in only one eye the brain may “ignore” the eye with blurred vision and selectively “choose” the vision from the clearer eye. Not until the better eye is inadvertently covered will the cataract be noticed. This can be experienced as a “sudden” loss of vision when really it is just the first time this change in vision has been noticed.
WHAT TO EXPECT THE DAY OF SURGERY

The big day has arrived. No doubt, you will feel some anxiety the morning of surgery. Relax. Most people say it’s not nearly as scary as they expected and that the anticipation is worse than the surgery itself.

Get a ride to the surgical center because you will not be able to drive home after surgery; you could be very woozy from any sedatives that may be given to you. Consider your ride to
the surgery center as an opportunity to reflect on how your surroundings look. Very soon, your world is going to be clearer, brighter, and more vibrant!

**AT THE SURGERY CENTER**

When you arrive at the surgery center, chances are there will be some additional paperwork to fill out. After you finish this, someone will take you into a pre-op area, where you may need to change out of your clothing and into a patient gown.

Normally, staff will ask you multiple times which eye is undergoing cataract surgery. You may be thinking, “Don’t they know? Maybe I’m at the wrong place.” There’s no need for worry. Surgical staff are often instructed to check and re-check to ensure they are operating on the correct person and the correct eye. At some point before surgery actually begins, your surgeon might even put a pen mark on your forehead above the eye. This is for your protection and serves as a reminder to everyone which eye is to be operated on. After surgery, you can remove this mark with an alcohol swab or let it disappear on its own after a few days.

Either in the pre-op area or the operating room, you may have an intravenous (IV) line placed in your arm. You’ll also have drops placed in your eye multiple times. The
drops dilate your pupil, making it easier for the surgeon to get a clear view inside your eye. It may take 20 to 60 minutes for your eye to dilate enough for surgery. Be patient. The larger your pupil, the better your surgeon’s view into the eye.

Once in the operating room, you’ll most likely be there for half an hour or so. About half of this time will be spent cleaning the area around your eye and placing a drape over your upper body. This protects your eye from any bacteria that could cause an infection.

A blood pressure cuff will be placed on one of your arms. Don’t be alarmed. It is routine to monitor blood pressure during surgery. The cuff will periodically inflate and squeeze your arm. Just try to relax and ignore it. It will deflate soon.

You’ll most likely be given a sedative through the IV to relax and bring you into a state called conscious sedation. This is not like general anesthesia, where you’re unconscious. Instead you’re brought into a sleepy, relaxed state.

I find that playing music during the procedure further relaxes patients. If you have a particular type of music you would like to play during the surgery, let your surgeon know. I offer my patients the opportunity to choose from more than 9,000 songs on my iPod, or I let them bring in their own CD or digital music player.
One of the effects of the sedative is temporary amnesia, so don’t be surprised if you don’t remember what happens next.

To numb the eye, your surgeon will give you either an injection of numbing medication or topical anesthetic. Traditionally, numbing medication is injected next to and behind the eye. This requires using a needle, which could potentially puncture the eye and lead to a loss of vision. For this reason, I prefer to use a topical anesthetic, which does not require an injection. Topical anesthetic is a liquid or gel applied to the surface of the eye prior to surgery.

There are multiple benefits of topical anesthetic — the main one is avoiding the risks associated with using a needle next to the eye. (Recall what your mother told you about sharp objects and the eye. The same motherly wisdom applies here.) Also, an injection often makes a patient’s vision blurry for several hours after surgery. With topical anesthetic, you’ll be able to enjoy your improved vision shortly after surgery.

While you’re still in a relaxed, sleepy state, your surgeon will begin the procedure. Typically two things will happen next: You’ll hear buzzing and bells coming from the equipment and possibly feel some cool fluid on the side of your face. The fluid helps keep the ultrasound cool and is nothing to worry about.

While your surgeon is removing your cataract and replacing it with an intraocular lens (IOL), you might feel pressure in your eye. However, you should not feel any pain during the surgery. If you do, let the surgeon know so that you can be given more anesthetic.

Try to keep focused on the microscope light without looking around or moving your head. The less you move your eye the
easier it will be for your surgeon to remove your cataract. Also, if you feel that you need to cough, let your surgeon know so he or she can safely pause the surgery.

When the procedure is over, your surgeon will place a protective eye shield over your eye. You’ll need to wear the shield continuously for the next 24 hours and then only when sleeping or napping for the week after surgery.

Staff will then transfer you to a recovery area for an hour or so where you’ll recover from the IV sedation. The entire process — from the time you arrive at the surgery center to the time you leave typically takes 2 to 4 hours.

**AFTER THE PROCEDURE**

The afternoon and evening following surgery, it’s normal to feel as if there is something in your eye, such as a grain of sand. This usually lasts for only a few hours, but can last up to a few days. Using the eye drops prescribed to you before the surgery can relieve the discomfort. Although it seems obvious, I’ve learned the hard way never to assume anything, so I’m going to say it: Don’t rub your eye!

You may be prescribed more eye drops. These will help prevent infection and treat the inflammation caused by surgery.

You should not experience significant pain. If you do, call
your surgeon. If needed, you may take acetaminophen for minor discomfort. Try to avoid aspirin or non-steroidal anti-inflammatory drugs (NSAIDs), such as Advil® and Aleve®, as they increase the chance of bleeding.

Your surgeon will likely tell you to take it easy for the rest of the day. Watching TV is generally what I recommend. This is a great time to get the family to wait on you. Let someone else make dinner or take out the garbage for a change.

You may still be groggy from the sedative, so don’t try to operate any machinery (such as a car). It’s okay to read, but your vision may seem “jiggly.” Because the lens capsule has not yet contracted around the IOL, there may be a slight jiggle of the lens with each eye movement. This is most noticeable when reading and will improve over the next few weeks.

The evening of surgery, your vision may or may not already be restored. However, even by that evening, many people notice that they can see things more clearly through the holes of the eye shield.

**Do surgeons ever operate on both eyes at the same time?** If you have cataracts in both eyes and your surgery is going to be done in the United States, you’ll have surgery done on one eye at a time. Typically, you’ll have surgery on the first eye and a second surgery on the second eye a month or so later. This will give your first eye enough time to heal before you undergo surgery on the other eye.
Typically, you will need to see your surgeon either the afternoon of surgery or the following morning. Most people’s vision improves by their first postoperative visit. However, if you have any other problems with your eye (such as astigmatism or macular degeneration), your vision might still be unclear. Also, unless you opted for one of the newer, advanced IOLs (discussed in a later chapter), you’re likely to still need glasses or contact lenses after cataract surgery.

At the first postoperative visit, I tell my patients that they no longer need to wear the shield during the day. However, for the week following the procedure, I ask them to continue wearing it whenever they sleep. It’s likely that your surgeon will want you to continue using your eye drops for the next 3 to 4 weeks.

Generally, I like to see my patients again the following week. You should not have any problems during this period. If you have any questions, concerns, pain, or loss of vision, call your surgeon. Even if it’s 3 a.m., call your surgeon. I am available around-the-clock for my patients, and it is never a “bother” for me to answer their questions.
Typically, it takes a month or so for your eye to heal completely.

Depending on the type of IOL you have, you’ll most likely still need to wear glasses some or most of the time. About 4 weeks after surgery, you should return to your optometrist for new glasses or contact lenses because your prescription will have changed.

Wearing sunglasses with ultraviolet protection is a good idea. However, if you have a Bausch & Lomb Crystalens® IOL, it is mandatory that you wear sunglasses with UV protection whenever you go outdoors.

ACTIVITIES

I tell my patients that, starting 24 hours after surgery, light aerobic activity is okay, such as riding on a stationary bike or walking on a treadmill. It’s also okay to wash your hair and face or to shower. Try to avoid lifting
heavy items (those over 20 pounds) or engaging in high-impact aerobic activities, swimming, or gardening. Don’t submerge your eye under water, but you can have water run over your eyes when they’re closed. It’s okay to wear makeup, but avoid eyeliner and mascara. Drive a car only if your vision is better than it was before surgery and if you met the legal requirements for driving prior to surgery.

Most people can return to their normal activities 2 to 4 weeks after surgery.

**WHY YOU MIGHT STILL NEED GLASSES**

Many people mistakenly think after cataract surgery they will no longer need glasses or contact lenses to see well. Unfortunately, this is not true for many people. Nearsightedness, farsightedness, and astigmatism are usually caused by irregularities of the cornea. During “standard” cataract surgery (the type covered by Medicare and most insurances) nothing is done to correct irregularities of the cornea. Only the clouded lens is replaced. This means most people still need to wear glasses or a contact lens for either near and/or distance vision and astigmatism. However, depending upon the type of IOL you chose, it’s possible to get by with needing glasses only on occasion. I’ll discuss IOL options in the next chapter.
# GENERAL POST-OPERATIVE INSTRUCTIONS

Properly caring for your eye after your procedure is important in the healing process, so keep the following instructions in mind.

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<thead>
<tr>
<th>DO THIS ...</th>
<th>AVOID THIS ...</th>
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<tr>
<td>For the first week following the procedure:</td>
<td></td>
</tr>
<tr>
<td>• Wear the eye shield the first day, then only while sleeping for the first week</td>
<td>• Rubbing your eyes and any unnecessary hand-to-eye contact</td>
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<tr>
<td>• Use your eye drops according to the schedule your doctor provides you</td>
<td>• Getting shampoo in your eye</td>
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<tr>
<td>• Keep all your appointments</td>
<td>• Getting sweat in your eye</td>
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<tr>
<td>• Clean your eyelid with a clean, wet washcloth</td>
<td>• Engaging in strenuous activity or playing contact sports</td>
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<tr>
<td>• Shower or bathe as usual</td>
<td>• Lifting anything weighing more than 20 pounds</td>
</tr>
<tr>
<td>• Light aerobic activity is OK</td>
<td>• Do not participate in water sports or activities.</td>
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<td></td>
<td>• Do not garden</td>
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<tr>
<td>Later on:</td>
<td></td>
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<tr>
<td>• Call the office if you are having any problems</td>
<td>• Avoid swimming or scuba diving for 1 month</td>
</tr>
<tr>
<td>• Keep your follow-up appointment in 2-4 weeks</td>
<td>• Avoid wearing eye makeup for 2 weeks</td>
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INTRAOCULAR LENSES

WHY YOU NEED AN IMPLANT

I often get asked whether it’s necessary to insert an artificial lens inside the eye during cataract surgery. My immediate thought is often, “Well, why wouldn’t you want a new lens in your eye?” I realize, however, that for many people the idea of placing a foreign object inside their eye is loaded with uncertainty, making them ask such questions as: “Are they safe?” “Will the lens move or dislocate?” “Will I feel it?” Indeed, there was a time when these concerns were justified. But that was about 50 years ago.

Today, however, lens technology has advanced so much that a surgeon must have a good reason not to replace the cataract lens with an artificial lens. Without a lens implant, or an intraocular lens (IOL), you would become very hyperopic (farsighted) and need very thick glasses or contact lenses to see anything clearly.

Modern IOLs are made primarily of acrylic or silicone. Both materials are clear, able to refract (bend or focus) light rays, and flexible. They’re safe, and you won’t even notice that they’re there.

In other words, with the advanced materials and designs used to manufacture today’s IOLs, there is little reason not to get one.
YOUR OPTIONS

Cataract surgery and coffee have something in common: Ten years ago there were few, if any, options for either one. If you wanted coffee, your options were simply with or without cream, sugar, or both. Similarly, if you had cataracts, you really didn’t have many IOL types to choose from.

Now, however, there is a dizzying array of options available to anyone who saunters up to the barista: “Coffee? Would you like a grande or venti? Cream, low-fat milk, or soy? Vanilla, sugar-free vanilla, caramel, mocha, or flavor-of-the-week?” The same is now also true of IOLs for cataract surgery: “Would you like a spheric or aspheric IOL? Astigmatism correction? How about the ability to see distance, intermediate, or up close?”

Since you can now select among multiple IOL options — a major improvement over just a few years ago — how do you choose? As an eye surgeon who has performed thousands of cataract surgeries, I can tell you it is not an easy decision but it is a very important one. If you’re planning to wait a little while before having surgery, chances are technology will improve even more over the next few years, increasing your menu of choices by the time you’re ready.

Currently, there are 2 categories of IOLs you can choose from:

- **Standard monofocal IOLs** – These are traditional implants that have been available for many years. The lenses are called **monofocal IOLs** because they are single-focus lenses (“mono” means “one”). They do
not provide depth of focus (a range of vision) nor do they correct for astigmatism (an irregular cornea). These replace the natural lens and take care of most (but usually not all) of the refractive error of the eye. “Refractive error” is the reason people need to wear spectacles or contact lenses. As long as the eye has a refractive error, spectacles will be needed for the clearest possible vision.

**New, advanced IOLs** – These are “premium” and technologically advanced implants, such as multifocal accommodating, or toric IOLs. They can provide improved near, intermediate, and distance vision, with some even able to treat astigmatism.

Your surgeon is like a cobbler. To better understand the differences between monofocal IOLs and advanced IOLs, I find it helpful to think of them as you would shoes. If your foot is a perfect size 8, you can easily find a good-fitting shoe on the shelves of almost any shoe store. But if your foot is a size 8¼, most off-the-shelf shoes will be either slightly too big or too small. You could try using foam inserts or wearing thin socks to make them fit. But if you want a perfect fit, you must see a cobbler who can custom-tailor your shoe so that it matches the exact measurements of your foot.

Monofocal IOLs are like off-the-shelf shoes. You can make them work, but they may not fit perfectly. To get a perfect-fitting IOL — one that fixes your cataract and also reduces your need for glasses — your surgeon will need to fit you with advanced IOL. Each type of IOL has its own set of advantages. Your surgeon, like a shoe cobbler, must custom-tailor your cataract surgery, taking extra measurements and then thoroughly evaluating the options to determine the best fit for your unique needs.
THE DECISION POINTS

So, which IOL should you choose? It depends. Take the time to research thoroughly and evaluate your options. You’ll want to choose an IOL that is the best for your eyesight, lifestyle, and budget. The following questions can help guide your choice.

How often do you want to wear glasses?

When ordering coffee, there’s one initial question to answer: Caffeinated or decaf? With cataract surgery, the initial question is: Will you mind wearing glasses afterwards? If the answer is no, then you’re done. Choosing a standard monofocal IOL and then wearing glasses after surgery will meet your needs just fine. Expect, however, to wear glasses for both distance and reading vision at all times.

Now, I know you have friends that “had cataract surgery and didn’t pay any extra for the lens” but they were lucky. Most likely they had no astigmatism so the monofocal IOL was able to correct most or all of their refractive error. If you are free of astigmatism there is a chance that you could also have good distance vision without glasses after cataract surgery with a monofocal IOL. But if you are expecting to be less dependent on glasses then you really should consider the options below.

Bottom line: if you choose the monofocal IOL expect to wear glasses or contact lenses after your cataract surgery.

Would you like to wear glasses only occasionally?

If you dream of throwing away your glasses forever, keep dreaming. There are currently no IOLs that will allow you
to do that. If, however, you would like to wear glasses only occasionally, then read on. The newer, advanced IOLs offer you some options. Please note, however, that all of the options below come at an additional cost which is rarely covered by Medicare or Commercial Insurance.

**Option #1:** You would like to reduce your dependence on glasses for distance vision (for example, for driving), but don’t mind wearing glasses for using the computer and reading. In this case, you may be a candidate for either an aspheric or toric IOL. The aspheric implant corrects what are called “higher-order aberrations” and offers excellent distance vision for those who do not have astigmatism. 

Astigmatism is essentially a distortion of the corneal surface. Since the cornea is curved it bends light just as a lens would. If the cornea is distorted this will cause a blur that most IOLs cannot compensate for. Lenses that compensate for astigmatism are called “toric” IOLs. If you have astigmatism you’ll need either a toric IOL or a second surgery, called corneal refractive surgery to restore your distance vision.
**Option #2:** You would like to reduce your dependence on glasses for distance and intermediate (computer) vision, but wouldn’t mind wearing glasses for close-up work. You currently have a couple of options available to you: a multifocal IOL, a pseudoaccommodating IOL, or “Blended Vision”.

The **AMO® ReZoom™** and **Alcon ReSTOR® +3** are multifocal IOLs that simultaneously focus two images onto the retina, allowing you to see both distance and intermediate objects at the same time. The trade-off, however, is that there will be small circles (halos) around lights at night. Most people get used to this with time, but a small number of people (about 5%) find these halos to be a significant distraction.

How do you know whether you will be one of these five percent? You don’t. However, my experience suggests that if you are a glass half full type of person, you will enjoy your new range of vision and likely view the rings as a mild distraction. If, however, you are a glass half empty type, then you may be better off with one of the other IOLs. Don’t know which type of person you are? Ask your friends or family — you may be surprised by their answers.

The **Crystalens®** is a pseudoaccommodating IOL. It uses tiny muscles in the eye to change the shape of the lens. This changes the focus of the IOL, giving you both distance and intermediate vision. (Two other lenses that also use pseudoaccommodation are Visiogen’s Synchrony® and Lenstec’s Tetraflex®. However, at the time of publication of this book only the Crystalens® was FDA-approved.) There are generally no halos associated with the Crystalens®. So,
what is the downside of this IOL? Not all people are able to “train” their eye muscles after surgery to get the desired range of vision.

Another option that can provide a nice range of daytime vision without spectacles is what is called “Blended Vision.” Blended Vision is similar to a contact lens correction technique called “monovision” but is better tolerated. It’s called “mono”-vision because the vision of “one” eye is targeted for distance and the other is targeted for near. Whereas not everyone can tolerate having one eye “set” for distance and the other eye set for near, most everyone who chooses Blended Vision enjoys a greater range of vision without halos or visual discomfort. This is because the difference in “set points” (or “refractive targets”) of the eyes is less than that used with monovision.

Blended Vision generally works best when a very flexible IOL is used (such as the Staar Nanoflex® or LensTec SofTec HD®). Because these IOLs are “standard” IOLs there is no additional lens fee for the patient to pay. However, in order for Blended Vision to work well your surgeon must address any existing astigmatism as well as perform additional testing and “refractive services” that will not be covered by insurance. For those patients who simply don’t have the budget for a Crystalens® or do not wish to deal with the halos associated with a multifocal IOL, this is a very nice option. As with any IOL choice, however, there may still be activities (such as night driving or reading small print) that still require the use of spectacles. Bottom line: If you want a range of vision without nighttime halos, but are willing to use reading glasses for close work, then the Crystalens® or Blended Vision might be for you.
**Option #3:** You would like to reduce your dependence on glasses for good distance and reading vision, but wouldn’t mind glasses for intermediate (computer) vision. You have two options available to you: the Alcon ReSTOR +4 IOL or the AMO TECNIS® Multifocal IOL. Both use what is called diffractive optics that split light to allow for near and distance focusing at the same time. Since 2 images are simultaneously focused on your retina, there will be small circles (halos) around lights at night. As with other multifocal IOLs, most people get used to this with time, but a small number of people (about 5%) find these halos to be a significant distraction. Additionally, you’ll still probably require glasses for intermediate vision work, such as computer use.

The above options come with an additional caveat: No matter which IOL you choose, you may still need nighttime driving glasses. That’s because when you drive at night your pupils dilate to let more light into the eye. This dilation also slightly changes your refractive error. Current IOLs can’t correct this. Generally, however, a pair of night-driving glasses will help.

Medicare does not cover the fee for refraction (the exam to determine what glasses you will need after surgery). Expect to pay between $50-$100 for this exam (plus the cost of those designer frames).
What's your budget?

You say, “Budget? But I thought insurance covered the cost of cataract surgery?” It generally does cover the cost of cataract surgery with a standard monofocal IOL, the only type of implant currently covered by Medicare and most insurance plans. However, with the newer, advanced options, you’ll have out-of-pocket costs that sometimes carry an additional price tag in the thousands of dollars.

Medicare and most other types of insurance do not pay for advanced IOLs because they classify these implants as cosmetic and not medically necessary “upgrades.” Consider, for a moment, Medicare’s perspective. A cataract is a medical condition. If it is affecting your daily activities, then Medicare classifies cataract surgery as medically necessary. Procedures that eliminate or reduce the need for glasses because of nearsightedness, farsightedness, or astigmatism, however, are considered elective surgery and not something that is medically necessary. For the same reasons, most advanced IOLs are considered “not medically necessary” and therefore not covered.

So, if you want your insurance to cover the entire tab for your surgery, a standard monofocal IOL will be your best choice, but expect to wear glasses after surgery for both distance and near activities.
“When I had the cataracts done it was a wonderful experience. Very fast, very professional. It was enjoyable to be able to see so well again.

Before I had the cataract surgery, everything was dull. You don’t think it’s as bad as it is until after the surgery when everything is so clear and so beautiful. You’ll find that it’s well worth the time and effort to have it done.

After the surgery, we did the drops for a few days. Within two weeks you would never know you had surgery done...”

- Betty
Cataract Surgery Patient
According to the National Eye Institute, cataract surgery is one of the safest and most effective types of surgery.\textsuperscript{1} Serious problems are rare. In fact, more than 97% of people have no complications with cataract surgery. That being said, any surgery still has risks.

Prior to cataract surgery, you will receive a consent form. (A sample informed consent form is included in the back of this book.) Generally, this form is written by attorneys who feel it necessary to list nearly everything except for “acts of God” as a risk of surgery. I’m not really sure why they leave out “acts of God.” I practice in southern California, where we have both earthquakes and rolling blackouts. Either of these events, were they to occur during cataract surgery, could have devastating consequences. Fortunately, my center, like most surgery centers, has backup electrical power for emergencies. As for the earthquakes...

However, if your surgeon tells you there are no risks to the surgery or that they have never had a complication, I’d question

that statement. All surgeons worth their salt have met with some complications. In fact, better surgeons tend to get the more difficult cases, so their experience with complications may be even higher than those of lesser skilled surgeons.

If you would like to find out how to choose a cataract surgeon, I have included a bonus chapter at the end of this book outlining 10 things you should know about your surgeon prior to cataract surgery. You may request extra copies of this chapter by calling my office at 626-289-7856. My staff will be happy to drop some extra copies in the mail for you.

OK, back to the risks of cataract surgery…

POSSIBLE COMPLICATIONS

Capsular tear

During surgery the biggest concern is often with the lens capsule. As I mentioned earlier, this delicate membrane occasionally tears, allowing fragments of the cataract to slip into the back portion of the eye. If a part of the cataract falls into the gel of the eye, you might notice floaters, or bug-like objects or specks that travel across your field of vision. Floaters are common and something you might notice when you go outside on a sunny day. However, if you notice a new floater after surgery, you should immediately let your surgeon know. If a lens fragment is causing the floater, it should be treated with a separate surgery (vitrectomy) at a later date.
Infection

Infection is one of the greatest risks. An infection from cataract surgery, known as endophthalmitis, can potentially lead to a loss of vision — even blindness — and can do so in a matter of hours. Fortunately, it is very rare: Only 1 person in a 1,000 gets it.

If you had an infection, you would know. Your eye would be red and/or painful, or you would have a sudden loss of vision. If you suspect an infection, call your surgeon immediately, even if it’s 3 a.m.!

Retinal detachment

Your lifetime risk for retinal detachment increases after cataract surgery to about 1 in 100, and even greater than this if you have moderate to severe nearsightedness or if the lens capsule tears during surgery. Symptoms of retinal detachment include floaters or flashes in your field of vision or a loss of an area of your vision. If symptoms are severe, your vision might appear shaded, as if a curtain had been placed over your eye. Fortunately, a detachment can often be treated with surgery. Call your doctor immediately.

Inflammation

Inflammation, or swelling, is the body’s natural healing response. Inflammation from cataract surgery can cause blurry vision. It usually goes away after a few weeks with treatment. Occasionally, it can cause elevated eye pressure, swelling of the cornea, or swelling of the retina. If it persists, inflammation can often be treated with eye drops or an injection. It is rare, however, for inflammation to cause a permanent loss of vision.
Posterior capsular opacification

Once your cataract has been removed, it won’t come back. That being said, it is possible for your vision to become worse after surgery from what’s called **posterior capsular opacification**. Simply stated, the lens capsule shrink-wraps around the IOL. As the capsule contracts, it can opacify (scar), causing glare, halos, or blurred vision. Because these symptoms are similar to those of a cataract, this used to be called a “secondary cataract.” However, this is a misnomer as it is not actually a cataract, but rather your body’s natural healing response. It has just healed a little too well. The risk of this happening with a modern IOL is somewhere between 5% and 15%. Considering that not so long ago surgeons told patients to just expect it, this low incidence is remarkable.

Fortunately, posterior capsular opacification can be removed with laser treatment. The procedure is painless and does not take very long. There are very few risks to this laser treatment. The vast majority of people who have it done

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**If you experience any of the following after surgery call your surgeon immediately:**

- Sudden or severe loss of vision.
- Significant or persistent pain in or around the eye.
- If you see flashes of light or multiple, new floaters.
- A shadow or curtain over your field of vision.
- Significant discharge from the operated eye.
- Nausea, vomiting or severe headache.
notice their vision improves within hours or days. As with any surgery, however, there are risks. If you were to require this treatment, ask your surgeon to discuss these risks prior to scheduling the surgery.

**IS THAT IT?**

I just covered some of the potential complications of cataract surgery. Read the sample informed consent at the end of the book to learn about other possible risks. Before having any surgery you will need to come to grips with the fact that, although rare, occasionally people have complications.

It is important to keep in mind that everything we do in life involves risk. When you cross the street, you know that even if you stay within the crosswalk something could happen. But you usually take that risk and cross the street anyway, because there is some place you need to get to on the other side.

With cataracts, the question you must ask is whether your vision is bothering you enough that you feel it is worth taking those real, but unlikely, risks of cataract surgery. If your cataracts are affecting your daily activities, then coming to terms with these rare complications might be the only way to stop poor eyesight from interfering with your life.
Listen to the testimonials of cataract and glaucoma sufferers. You will realize that just like you, they too had a lot of fears before undergoing their eye procedures. But look at them now! They not only got their vision, but their life back as well.

visit: http://david-richardson-md.com/testimonials/
CATARACT SURGERY AND GLAUCOMA

Glaucoma is a condition that commonly occurs in the same age group as those with cataracts. As such, it is often necessary to address glaucoma at the time of cataract surgery. Glaucoma is a topic that is too big to cover adequately in this book, but I have created a website that discusses glaucoma and its treatments in more detail at www.New-Glaucoma-Treatments.com.

After cataract surgery, there is a risk that your eye pressure, or IOP, could increase. Fortunately this pressure elevation is usually temporary and treatable with drops, laser treatment, or, occasionally, additional surgery. In a healthy eye, it’s rare for this pressure elevation to cause vision loss.

However, if you have ocular hypertension (generally considered to be an IOP greater than 21mmHg), glaucoma, or a condition known as pseudoexfoliation syndrome (deposits on the surface of the lens), you may be at an increased risk for vision loss due to a spike in eye pressure. Especially if you have glaucoma, your eye might not be able to tolerate even a temporary elevation in pressure. At times it may even be necessary to surgically treat the glaucoma at the same time as cataract surgery.
**IF YOU HAVE EARLY OR WELL-CONTROLLED GLAUCOMA**

I have good news for you. Recent studies have shown that cataract surgery alone may decrease the intraocular pressure (IOP). Thus, if you have only mild (or well controlled) glaucoma both your vision and your IOP may improve with cataract surgery alone.

**IF YOUR GLAUCOMA IS MODERATE OR REQUIRES THE USE OF DROPS**

Good news again – there are now multiple glaucoma treatment options that can be performed at the same time as cataract surgery.

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At the time this book was published the following procedures were FDA approved in the United States.

**Trabectome**

This procedure uses a small instrument that opens a section of the trabecular meshwork (the small filter inside the eye that can get “clogged” resulting in high IOP). Once the meshwork is open the fluid in the eye should be able to get to the “collector channels” thereby reducing the IOP. In general, this procedure (when combined with cataract surgery) can lower the IOP into the mid teens. Often there is bleeding inside of the eye that can blur vision after Trabectome but it generally resolves in a week or two. The major downside of this surgery is that once it is done other glaucoma surgeries

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such as Canaloplasty and placement of an iStent cannot be done. In other words, this procedure “closes doors” on the ability to use other promising glaucoma treatments.

**EndoCycloPhotocoagulation (ECP)**

This procedure uses a small laser probe to heat up and destroy the ciliary body (the tissue that produces fluid in the eye). There is limited peer-reviewed information available about the effectiveness of this procedure, though it appears to be able to lower the IOP into the teens when combined with cataract surgery. Although a fast procedure, it does cause significant inflammation after surgery which can result in temporary discomfort and blurring of vision.

**Glaukos iStent**

FDA approved in 2012, this snorkel-shaped device can be implanted into the eye’s drainage canal during cataract surgery with seemingly minimal risk or additional time. The downside is that a single iStent only lowers the IOP by a couple of points so the effect is limited.\(^\text{10}\) Outside of the USA, multiple stents can be placed (with additive effect)\(^\text{11}\) but the FDA has approved the use of only one iStent per eye and only at the time of cataract surgery. Also, whether insurances will pay for this is uncertain.

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\(^\text{11}\) Belovay GW, Ahmed II. *Using multiple trabecular micro-bypass stents in cataract patients to treat primary open-angle glaucoma.* Presented at: The ASCRS Symposium on Cataract, IOL and Refractive Surgery; April 9-14, 2010; Boston, MA.
Canaloplasty

Canaloplasty can best be thought of as “angioplasty for the eye.” Using the world’s smallest microcatheter, the eye’s natural drainage system is dilated and stented open – reestablishing the normal flow of fluid out of the eye. Because it is safer than the more traditional glaucoma procedures\textsuperscript{12} (trabeculectomy and tubes – see below) and more effective than the other procedures listed already, it is currently one of the fastest growing glaucoma procedures. When combined with cataract surgery the IOP is reduced by

\begin{center}
\textbf{Enlarged drainage channels}
\end{center}

[Used with permission from iScience Interventional, Menlo Park, CA]

\textsuperscript{12} Tam D, Calafati J, Ahmed I. \textit{Non-penetrating Schlemm’s canaloplasty versus trabeculectomy}. Paper presented at: The American Society of Cataract and Refractive Surgery Annual Meeting; April 6, 2009; San Francisco, CA.
an average of 42%\textsuperscript{13} resulting in an IOP in the low-to-mid teens for most patients. Additionally, most patients who have combined cataract surgery and canaloplasty are off all of their glaucoma medications after surgery!

\section*{IF YOU HAVE ADVANCED OR POORLY-CONTROLLED GLAUCOMA}

With advanced glaucoma the risk of vision loss after any surgery is higher. An IOP spike could result in sudden (even complete) loss of vision. Therefore it is critical that the IOP be controlled during the post-operative period. For this reason a “combined” procedure is generally recommended at the time of cataract surgery. The most commonly recommended procedures for those with advanced glaucoma who need cataract surgery are:

\textbf{Trabeculectomy}

The oldest of modern glaucoma surgeries, a trabeculectomy (also known as a “trab”), involves punching a hole in the eye and then trying to control the amount of fluid that percolates under the thin surface layer of tissue (called the “bleb”). Although it is possible for trabeculectomy to lower the IOP into the single digits, the IOP lowering effect of trabeculectomy is weakened when done at the same time as

cataract surgery\textsuperscript{14} – thus making this a less than ideal choice to combine with cataract surgery. Additionally, trabeculectomy adds significant risk to cataract surgery, can result in long-term “dysesthesia” (a sense that something is on the surface of the eye), and is not an appropriate choice for soft contact lens wearers or those who enjoy water sports.

\textbf{“Tubes” or Stents (aka Setons)}

This surgery involves placing a silicone tube in the eye which allows fluid to flow just underneath the surface of the eye along a plate that is sewn onto the eye wall (sclera). Generally, this surgery can achieve IOPs in the low to mid-teens.\textsuperscript{15} However, as with all body implants, there are risks associated with movement of the implant as well as scarring around the implant.

\textbf{Canaloplasty}

As mentioned earlier, canaloplasty restores the natural drainage of the eye without creation of a fistula, bleb, or external device. As such, it is not as risky as trabeculectomy or “tube” surgery. An additional advantage is that (unlike trabeculectomy) it works better when done with cataract surgery than when done on its own. So why doesn’t every surgeon offer canaloplasty? For one, it is technically more challenging than trabeculectomy or tube surgical strategies for coexisting glaucoma and cataract: an evidence-based update. Ophthalmology 2002;109:1902-13.

placement. Nevertheless, because it is a safer procedure than either “trabs or tubes,” it is worth considering if your surgeon is recommending both glaucoma and cataract surgery. For more information about Canaloplasty, visit www.New-Glaucoma-Treatments.com

**Summary of Glaucoma Treatment Options**

Fortunately for those with both cataracts and glaucoma, there are now many good treatment options available to both improve (cataract surgery) and protect (glaucoma surgery) the vision. Which option is most appropriate for you will depend on the severity of your glaucoma and the comfort of your surgeon with the available glaucoma treatment options.
CHAPTER NINE

CATARACT SURGERY WITH OTHER EYE DISEASES

For most people, cataract surgery successfully restores vision. However, it helps to have an otherwise healthy eye. People whose vision fails to improve after cataract surgery — about 3% of patients — often have other underlying diseases or eye disorders.

DIABETIC RETINOPATHY

Unfortunately, when you have diabetic retinopathy (eye damage that occurs with long-term diabetes) you are at higher risk of macular edema (swelling of the retina) or infection. These conditions can be challenging and require prolonged treatment with steroids or other topical medications or injections in the eye, as well as laser treatment. If you have diabetes, the most important thing you can do to limit additional risks of cataract surgery is to maintain good control of your blood sugar.

MACULAR DEGENERATION

There has been a lot of controversy surrounding cataract surgery and macular degeneration, a degenerative condition of the retina.
A few years ago, some published studies suggested a link between cataract surgery and the progression of this disease.

As of the date this book was published, the most up-to-date studies have shown little evidence that cataract surgery causes macular degeneration to progress\(^{16}\), offering some reassurance to patients with the condition. I have also discussed this very issue with multiple retina specialists. In general, they recommend proceeding with cataract surgery for patients with macular degeneration, as it is much easier for them to follow and treat retinal disease once the cataract has been replaced with a clear artificial lens.

**PROSTATE MEDICATIONS**

Prior to cataract surgery your surgeon must dilate the iris to safely remove the cataract. It must stay dilated to enhance the surgeon’s view inside your eye and to avoid damaging your pupil — a very delicate tissue — when removing the cataract.

A few years ago Dr. David Chang, an ophthalmologist in San Francisco, noticed that the iris of certain patients would become “floppy” during cataract surgery, which interferes with dilation and increases the risk of damaging the pupil. This interference is called **intraoperative floppy iris syndrome** (IFIS).\(^ {17}\)

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Drs. David Chang and John Campbell, with the help of others, collected all the information they could about those patients who suffered from IFIS and discovered that they had one thing in common: the use of a prostate medication called Flomax® (tamsulosin).

Flomax is a medication that relaxes the smooth muscle of the prostate, allowing men with an enlarged prostate, or benign prostatic hyperplasia, to urinate more easily. Doctors also prescribe this medication for women as a treatment for urinary retention. Unfortunately, it appears that this smooth-muscle relaxant also has a permanent effect on the muscles that control the iris, interfering with the pupil dilation necessary for cataract surgery.

Other medications used for enlarged prostate include the newly released RAPAFLO® (silodosin), as well as a group of medications known as “non-selective” alpha-1 adrenergic antagonists. This group includes Hytrin® (terazosin), CARDURA® (doxazosin), and Uroxatral® (alfuzosin). These drugs are less likely than Flomax® to cause IFIS, although it can still happen.

Make sure your surgeon knows if you are taking any of these medications.

Important note! Notify your cataract surgeon and surgical team if you are taking a medication for an enlarged prostate. They’ll need to take extra precautions prior to or during your surgery to minimize the risks of IFIS.
“I’ve had cataract surgery on both of my eyes. I’m very happy with surgery. It went well. I had no problems after the surgery. I’m very pleased. The vision is improved significantly. Colors are very, very vivid now - blues and reds. Distance vision is good. I still need reading glasses, but that’s not a big encumbrance. My vision before surgery was bad. I had to wear trifocal lenses. My night vision was bad. Distance vision, even with correction, was not that good. A big difference between then and now. I’m very, very pleased

- Frank Brion
Cataract Surgery Patient
Lasers evoke images of the future, science fiction, and advanced technology. It is no surprise then that somebody came up with the idea of using a laser to remove a cataract. The problem is, the initial attempts at using a laser in the late 1990s didn’t work as well as other treatment options, so the technology never took off and very few eye surgeons used this technology.

So why do so many people believe they have had “laser cataract surgery” when so few doctors were even offering this as an option? Because the second most commonly performed surgery in the USA is a laser procedure used to remove haze that can sometimes form behind the lens after cataract surgery. This haze (properly called “posterior capsular opacification”) used to be described as a “secondary cataract” or “after cataract.” Because the terms doctors used with their patients had the word “cataract” in them and the treatment to remove this haze used a laser, it is not surprising that many people confused the terms “after-cataract” or “secondary cataract” with “cataract” and mistakenly believed that their cataracts had been removed with a laser.
I’m not suggesting that some of the people you’ve talked to haven’t had laser surgery. They might have had refractive laser surgery, such as LASIK, to improve their eyesight. But it is very unlikely that they actually had their cataract removed with a laser.

**ENTER THE FEMTO LASER**

Fast forward now to 2012. A newer laser technology previously used by LASIK surgeons has recently caused quite a stir among cataract surgeons (and not all of the “buzz” is positive). Touted by some as “Laser Cataract Surgery,” it would be more aptly named “Laser Assisted Cataract Surgery.” Among cataract surgeons it is more commonly termed Femto-Phaco as it requires a combination of Femto laser treatment and phacoemulsification to complete the surgery.

So, what exactly does this Femto laser do and is it better or safer than standard phacoemulsification? That is, as they say, is the $64,000 question. To date there is no clear answer, but to help you form your own view I will try to briefly outline the pros and cons of this new technology.

**A Brief History of Femto Laser use in Eye Surgery**

This technology was originally used by eye surgeons to create the flap in LASIK surgery. The flap is made by creating a very thin slice of the cornea. Prior to using the Femto laser, this flap was made using an oscillating metal blade called a microkeratome. As with any mechanical item these microkeratomes occasionally malfunctioned resulting
in sight-threatening complications. The Femto laser has the ability to create microscopic spaces in clear tissue (such as the cornea). If you think of these separations as similar to the holes in a perforated page, you can easily imagine that if you placed many of these spaces side-by-side that you could then peel away a flap of corneal tissue rather than cutting it with a metal blade. In practice, Femto-LASIK met with its own set of complications (such as flaps that did not “tear away” as predicted (similar to how perforated paper doesn’t always tear the way you think it should). Nevertheless, this technology took off and is in wide use today. Whether its current popularity is a result of marketing “All Laser LASIK” or because it is a safer, better method of performing LASIK is still debated among eye surgeons.

A short while after the development of Femto laser technology a well-respected and forward-thinking eye surgeon, Dr. Sam Masket, showed that the same Femto technology used in LASIK could create the corneal incisions made at the beginning of cataract surgery. Since this laser can cut most clear tissues it also made sense that this laser might be able to create the capsulorrhexis as well as “soften” certain types of cataracts before removal. As with Femto-LASIK, however, the practical reality does not always live up to the promise or the hype. Let’s discuss each potential advantage of Femto-LASIK and compare it to the possible downside.

**Femto Laser use in Cataract Surgery - Potential Advantages**

**Creation of the Initial Corneal Incisions**

In theory an incision made with the Femto laser could “self-seal” resulting in a lower risk of infection. To date, however, this potential advantage has not been proven.
Creation of the Initial Continuous Curvilinear Capsulorrhexis

One of the major challenges in modern cataract surgery is “hitting the refractive target.” In other words, improving the surgeon’s ability to choose the correct IOL. In theory, a perfectly round, centered and sized capsulorrhexis could decrease some of the variability that currently limits a surgeon’s ability to “hit the target.” However, not only is this theory unproven, recent evidence suggests that in the hands of an experienced surgeon (1) capsule complications are rare, and (2) the position of the capsule edge relative to the IOL had no effect on final refractive outcome.¹⁸

“Softening” of the Cataract

The energy used to emulsify the cataract with ultrasound can damage the cornea. Therefore, if the cataract could be made softer by cutting it into pieces with a laser prior to ultrasound then there may be less damage to the eye during cataract surgery.

Correction of Refractive Error
The Femto laser can be used to place “relaxing incisions” in the cornea to address astigmatism at the time of cataract surgery. In theory these would be more predictable than incisions made with a metal or diamond blade.

Femto Laser use in Cataract Surgery - Potential Disadvantages

Creation of the Initial Corneal Incisions
All of the incisions and cuts made by the Femto laser require an additional procedure prior to cataract surgery. In general, the laser is “docked” onto the eye for proper alignment. This docking has the potential to affect the corneal surface blurring the surgeon’s view during the actual cataract surgery. Additionally, the currently available metal and diamond blades used to create the corneal incisions are so sharp that these incisions often self-seal anyway. It is simply not known whether the Femto laser incisions will seal better than incisions made with a diamond or metal blade.

Creation of the Initial Continuous Curvilinear Capsulorrhexis (CCC)
Creation of the CCC is technically challenging for the beginning surgeon. Most experienced cataract surgeons,
however, are quite adept at creating a well-centered capsulorrhexis. The most feared risk is that of a tear resulting in a dropped lens. The Femto laser does not eliminate this risk. Indeed, for surgeons who are new to the Femto laser this risk actually increases! 19

“Softening” of the Cataract
Modern ultrasound technology is so efficient that it is rare for the ultrasound energy to cause irreversible damage to the cornea. When this happens, it is often because there is corneal disease or a very dense cataract. Unfortunately, the Femto laser does not work well with either a diseased (swollen) cornea or a dense cataract. So if Femto laser cannot “soften” a very dense cataract, what is the benefit of “softening” a cataract that is already “soft”?

Correction of Refractive Error
The type of corneal incisions the Femto laser can create to reduce astigmatism are the same type that can also be done with a metal or diamond blade. No one knows whether this will work better (be more predictable or get greater effect) with the laser. What we do know is that the Eximer laser (PRK or LASIK) does a very good job of correcting residual refractive errors—which has many surgeons (myself included) asking the question, “If we’re going to use the Femto laser, why not just use it to create a LASIK flap before cataract surgery and plan on correcting the residual refractive error after cataract surgery with the Eximer (the laser used for corneal refractive surgery)?”

The Achilles Heel of Femto Laser use in Cataract Surgery - Cost

Assuming you feel the potential advantages of Femto-phaco outweigh the disadvantages (or perhaps you just think that lasers are “cool” and would like to say to your friends that you had “laser cataract surgery”), why not choose the laser option? There is one very good reason to forgo Femto-phaco: cost.

**Cost**

Femto-phaco is not cheap. Depending on where you have it done it can add $500-2,000 per eye to the cost of cataract surgery. This is in addition to the fee for “refractive cataract surgery” or the “premium lenses” (IOLs). As with refractive surgeries, Medicare and most major commercial insurances do not cover it. So if you want laser, you’ll have to pay for laser.

**Value – Is Femto-Phaco Worth the Price Tag?**

OK, so let’s say you’re part of the 1% (or 5%) that is at risk of being mobbed at an Occupy Wall Street demonstration. You don’t give a whit about cost – this is about scoring points with your buddies at the country club or wine tasting event. By all means, Femto-phaco will give you bragging rights.

But, for the rest of us, what are we really getting for our hard-earned money? Well, it’s not so clear that there is a real, measurable advantage to using Femto-phaco. Let’s take another look at the current uses of Femto laser with cataract surgery:
Creation of the Initial Corneal Incision
Is a laser corneal incision better than one made by a metal or diamond blade? To answer that we need to ask what “better” means. For most surgeons “better” would be water-tight or “self-sealing.” A self-sealing incision is one that does not leak, does not require a suture, and decreases the risk of infection after surgery. To date there is no evidence that incisions made with a Femto-laser seal any better than those made with a metal or diamond blade. Bragging Rights, +1, Real Value, 0.

Creation of the Initial Continuous Curvilinear Capsulorrhexis (CCC)
Granted, for an inexperienced surgeon the creation of a CCC can be nerve-racking. But, if you are having cataract surgery why would you voluntarily choose an inexperienced surgeon (see appendix section on choosing your surgeon)? In the hands of an experienced surgeon the risks of creating the CCC are exceedingly small. As for the potential benefit of a perfectly round, centered, and sized CCC? Dr. Jim Davison presented a paper at the 2012 annual meeting of the American Society of Cataract and Refractive Surgery which showed no benefit in refractive outcome with the Femto created CCC.20 Bragging Rights, +1; Real Value -1.

“Softening” of the Cataract
It’s already been mentioned that the Femto fails to create real value where it is needed most: dense, hard cataracts in patients with corneas at risk. Bragging Rights, +1; Real Value, 0.

Correction of Refractive Error
Frankly, the idea of using a Femto laser to create limbal relaxing incisions (LRIs) just seems like using a backhoe to fill a flower pot. These incisions can be easily made with a diamond or metal blade (for a fraction of the cost to both the patient and the doctor). Additionally, the real value of the Femto laser (when discussing refractive surgery) is in the creation of the LASIK flap (which it does very well). With LASIK (or even PRK) any residual refractive error (not just astigmatism) could be corrected after the eye has healed from cataract surgery. Bragging Rights, 0; Real Value, 0.

Femto-Phaco Final Tally: Bragging Rights, +3, Real Value, -1
So, assuming you agree with my scoring, what does one get with the currently available (2012) Femto-Phaco technology? Basically bragging rights, but…these bragging rights come not only with significant extra cost, but also extra risk.

It just seems to me (as well as many other surgeons with whom I’ve discussed this topic) that if someone is going to spend the extra money on “laser refractive cataract surgery” the best current option would be to choose either an “advanced IOL” or Blended Vision and correct any residual
refractive error with the Eximer laser once the eye has fully healed. Maybe it’s not the “newest” version of cataract surgery available, but its risks are known and the “value” is high.

Then again, I’ve never understood why people pay over $1,000 for a set of golf clubs or a handbag either…
21st century cataract surgery is truly one of the miracles of modern medicine. If you are considering cataract surgery you can find assurance in the fact that it is one of the safest and most effective surgeries performed. My hope is that you have found this book both informative and anxiety relieving.

Even with the relatively fast manuscript-to-publication time of eBook publishing, newer advances in cataract surgery might not be reflected in this book by the time you purchase it. If you would like to review the most up-to-date information, visit my blog at www.About-Eyes.com, where I provide updates regarding cataracts and the modern state of cataract surgery.

In addition, I have produced a companion audio CD for those whose vision is too poor to read even the large print of this book. Copies of this CD can be purchased online at www.amazon.com/author/davidrichardson. Or if you live in the Los Angeles area, drop by my office and ask for a complimentary copy.

My address is 207 South Santa Anita Street, Suite P-25, San Gabriel, CA 91776.
“I’m so grateful to have my vision restored to the extent that it has been. I can read anything I pick up, including fine print. I can see clearly at a distance. I drive. For the first time in my life since high school, I’ve been without glasses, other than sunglasses, of course.”

It’s something I never, ever thought I would be able to enjoy.”

- Linda Kruger
Cataract Surgery Patient
Most people consider their eyesight to be their most important sense. Yet, each year millions of people have eye surgery without doing any research on their surgeons. Who performs your cataract surgery is one of the most important decisions you will ever make. Luckily, it doesn’t take a lot of time to do the research necessary to find an excellent eye surgeon. The following list of 10 things you must know before choosing your cataract surgeon will explain how to go about it. With this list you can find an exceptional eye surgeon in less time than many people devote to choosing their next car.

1. **Use caution when evaluating “in-network” physicians.**

   Despite what’s stated in your health insurance’s marketing materials, don’t assume in-network physicians provide better quality care. Currently there isn’t a tried-and-true, scientifically sound method for rating the quality of physicians. Any insurance company that suggests physicians participating in its own network provide better quality care is painting an inaccurate picture.
2 **Ask people you trust.**

Good sources of information include your internist, optometrist, and friends who have had cataract surgery. Even better sources are the operating room nurses and staff at your local hospital. They are often in surgery with eye doctors and know who has the “best hands.” Nurses are, by nature, very helpful people and will often be happy to answer your questions. The challenge will be getting past the hospital’s automated telephone menu and gaining access to a live operating room nurse. I would suggest calling the hospital’s main number in the morning. Choose the option for a live operator. Once you have a live person, ask to be transferred to the operating room nursing station. A nurse will often pick up once the line is transferred.

3 **Research your surgeon’s education.**

Where did your eye surgeon train? It’s fairly easy to check the ratings for various training programs. Two objective resources are U.S. News & World Report’s annual rating of:

- “Best Medical Schools”
  

- “Best Ophthalmology Hospitals”
  

Don’t get too hung up on the ranking order. Surgeons trained at any of the top 20 institutions received a top-notch education.
4 **Research your surgeon’s state licensure.**
Make sure your surgeon is licensed to practice medicine in your state. Go to your state medical board’s Web site and do an online search. In addition to confirming a surgeon’s licensure, many state license Web sites will also tell you whether there has been any disciplinary or legal action taken against your surgeon. In California, for example, you can look up this information at [www.medbd.ca.gov/lookup.html](http://www.medbd.ca.gov/lookup.html)

5 **Confirm that your surgeon is board-certified.**
When physicians become board-certified, it guarantees they have met minimum competency requirements. In order to become certified, an eye surgeon must successfully pass both a written and oral examination. Additionally, younger surgeons must recertify every 10 years. Confirm that your ophthalmologist is board-certified by visiting [www.abop.org](http://www.abop.org) or [www.abms.org](http://www.abms.org)

6 **Visit your surgeon’s Web site.**
You can often obtain very useful information from your eye surgeon’s Web site. However, keep in mind that the primary goal of most Web sites is to market the practice. You won’t find anything negative about your doctor there, but it can give you more insight into the surgeon’s background and practice philosophy.
Find out what other patients have experienced.

Are testimonials from satisfied patients available on your surgeon’s Web site or physician-ranking Web sites? Can you review testimonials in your surgeon’s office? Will your surgeon provide the names and phone numbers of patients who have offered to act as references? It shouldn’t be too hard for your surgeon to come up with a list of people willing to discuss their cataract surgery experience with you. Keep in mind, however, that federal privacy regulations limit the amount of information a surgeon may be able to offer regarding other patients who have had surgery.

Find out how many cataract surgeries your doctor has performed.

There is a reason they call it the “practice of medicine.” Just like a sports pro, a surgeon’s abilities improve with practice and experience. Every surgeon requires a minimum number of “cases” to become proficient. For cataract surgery, this number is probably around 500. Still not comfortable? Find someone who has performed over 1,000 cataract surgeries.
How do you find out the number of cataract surgeries your surgeon has done? Just ask. If you are uncomfortable asking this question, then bring someone to your appointment who will ask for you. This is a very important question. These are your eyes. You only have two. Get over your hesitation.

9 Meet your surgeon.
One of the most important criteria for choosing surgeons is your ability to trust them. Meet with your surgeon. Make sure you feel comfortable with what your surgeon says and with the level of care that will be provided. Trust is an important consideration that cannot be sufficiently developed until you talk with your surgeon face to face.

10 Finally, get a second opinion.
Most people wouldn’t purchase a car without test-driving at least one other car. Cataract surgery is a very important decision and getting a second opinion is a smart idea. Many people are uneasy about getting another opinion, but a second opinion is a common medical practice encouraged by the best surgeons. In fact, one quick test of your surgeon’s comfort with their own abilities is to let them know that you’ll be getting a second opinion. If the surgeon becomes defensive about this, then you’ll know a second opinion is a good idea, after all.

Unless you are completely comfortable with your surgeon, get a second opinion.

I would be pleased if you selected me as your surgeon (or would be happy to offer a second opinion). Call my office at 626-289-7856 or request an appointment online at www.David-Richardson-MD.com.

My staff will be happy to set up a time for us to meet.
“Dr. Richardson gave me two surgeries for cataracts and it opened up a whole new world for me...”

- Opal
Cataract Surgery Patient
Following is an example of a typical “informed consent” document. Your surgeon will require that you sign a similar document prior to surgery. It may be more or less detailed, but you will need to (1) read it or have it read to you; (2) understand what it says or at least feel you are aware of the issues; and (3) sign the document prior to surgery.

**WHAT IS A CATARACT AND HOW IS IT TREATED?**

The lens in the eye can become cloudy and hard, a condition known as a cataract. Cataracts can develop from normal aging, from an eye injury, or if you have taken medications known as steroids. Cataracts may cause blurred vision, dulled vision, sensitivity to light and glare, and/or ghost images. If the cataract changes vision so much that it interferes with your daily life, the cataract may need to be removed. Surgery is the only way to remove a cataract. You can decide not to have the cataract removed. If you don’t have the surgery, your vision loss from the cataract will continue to get worse.
HOW WILL REMOVING THE CATARACT AFFECT MY VISION?

The goal of cataract surgery is to correct the decreased vision that was caused by the cataract. During the surgery, the ophthalmologist (eye surgeon) removes the cataract and puts in a new artificial lens called an intraocular lens or IOL. Cataract surgery will not correct other causes of decreased vision, such as glaucoma, diabetes, or age-related macular degeneration. Most people still need to wear glasses or a contact lens after cataract surgery for either near and/or distance vision and astigmatism.

WHAT TYPES OF IOLS ARE AVAILABLE?

Your ophthalmologist will help you decide on the type of IOL that will replace your cloudy lens. There are IOLs available to treat nearsightedness (myopia), farsightedness (hyperopia), and astigmatism. IOLs usually provide either near or distance vision: These single-focus lenses are called monofocal IOLs. Some newer IOLs can provide for near, intermediate, and distance vision: These multiple-focus lenses are called multifocal IOLs. IOLs that treat astigmatism are called toric IOLs. You can also have one eye corrected for near vision and the other for distance vision, a choice called monovision.

WHAT IS ASTIGMATISM? ARE THERE OTHER TREATMENTS FOR IT?

Patients with nearsightedness and farsightedness often also have astigmatism. Astigmatism is caused by an irregularly shaped cornea; instead of being round like a basketball, the cornea
is shaped like a football. This can make your vision blurry. In addition to toric IOLs, astigmatism can be reduced by glasses, contact lenses, and refractive surgery (LASIK or PRK). There is also a procedure called a limbal relaxing incision (LRI), which can be done at the same time as the cataract operation, or as a separate procedure. An LRI is a small cut or incision the ophthalmologist makes into your cornea to make its shape rounder. Any attempt at astigmatism reduction could result in over- or under-correction, in which case glasses, contact lenses, or another procedure may be needed.

**WHAT ARE THE MAJOR RISKS OF CATARACT SURGERY?**

All operations and procedures are risky and can result in unsuccessful results, complications, injury, or even death, from both known and unknown causes. The major risks of cataract surgery include, but are not limited to, bleeding; infection; injury to parts of the eye and nearby structures from the anesthesia, the operation itself, or pieces of the lens that cannot be removed; high eye pressure; a detached retina; and a droopy eyelid. The major risks of a limbal relaxing incision are similar to those for cataract surgery, but also include loss of vision, damage to the cornea, and scarring; Under- or over-correction could also occur.

Depending upon your eye and the type of IOL, you may have increased night glare or halos, double vision, ghost images, impaired depth perception, blurry vision, and trouble driving at night. The ophthalmologist might not be able to put in the IOL you choose. In addition, the IOL may later need to be repositioned or replaced.
Depending upon the type of anesthesia, other risks are possible, including cardiac and respiratory problems, and, in rare cases, death.

There is no guarantee that cataract surgery or astigmatism reduction will improve your vision. As a result of the surgery and/or anesthesia, it is possible that your vision could be made worse. In some cases, complications may occur weeks, months, or even years later. These and other complications may result in poor vision, total loss of vision, or even loss of the eye in rare situations. You may need additional treatment or surgery to treat these complications. This additional treatment is not included in the fee for this procedure.

**PATIENT’S ACCEPTANCE OF RISKS**

I understand that it is impossible for the doctor to inform me of every possible complication that may occur. By signing below, I agree that my doctor has answered all of my questions, that I have been offered a copy of this consent form, and that I understand and accept the risks, benefits, and alternatives of cataract surgery. I have checked my choice for astigmatism correction and type of IOL.

______ **Monofocal IOL/Glasses Option**

I wish to have a cataract operation with a monofocal IOL on my ____ (state “right” or “left” eye) and wear glasses for both distance and near vision.
Monovision with 2 IOLs Option (may still need glasses)
I wish to have a cataract operation with 2 different-powered IOLs implanted to achieve monovision. I wish to have my _______ (state “right” or “left”) eye corrected for distance vision. I wish to have my _______ (state “right” or “left”) eye corrected for near vision.

Multifocal IOL Option (may still need glasses)
I wish to have a cataract operation with a_______(state name of implant) multifocal IOL implant on my _______(state “right” or “left”) eye.

Toric Monofocal IOL/Glasses Option for Astigmatism Reduction
I wish to have a cataract operation with a toric monofocal IOL on my_______(state “right” or “left” eye) and wear glasses for ________(state “near” or “distance”) vision.

Limbal Relaxing Incision for Astigmatism Reduction (may still need glasses)
I wish to have this procedure done in addition to the cataract operation.

_________________________________________________________  ________
Patient (or person authorized to sign for patient)       Date
“I had cataract surgery. It was so easy that I couldn’t believe that I had it done. It was just the simplest, easiest, painless operation I’ve ever had....”

- Tom Lemon
Cataract Surgery Patient
A PERSONAL NOTE

I hope this book has been informative. If you are a patient of mine, you should have received this information before your pre-operative visit. I encourage you to write down any questions you may still have so that I may address them when I see you prior to cataract surgery.

Although I cannot say I know what it’s like to have cataract surgery, after performing thousands of surgeries, I have a good sense of what concerns are commonly shared by people, such as yourself, who are about to undergo cataract surgery. You have my commitment that I, as well as the surgery team, will take the precautions necessary to decrease avoidable risks and address any apprehension you may have before and during surgery. My goal is for you to think it was a “piece of cake” and wonder why you waited as long as you did to get the cataract out.

If you would like me to evaluate your eyes and provide you with a consultation, call my office at 626-289-7856 or visit my website at www.David-Richardson-MD.com
YOUR FEEDBACK IS IMPORTANT

I know it is difficult to find time for this request, but if you wouldn’t mind giving me some feedback I’d be very appreciative. If you think other patients would benefit from reading this book then I hope you will write a “review” or “testimonial” that I could add to the book’s website, as well as other marketing materials.

Thank you!

Share Your Feedback at:
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