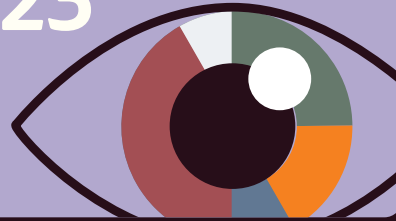


IME SUPPLEMENT | SEPTEMBER 2024

EUROTIMES



ESCRS Clinical Trends Survey 2023 Results



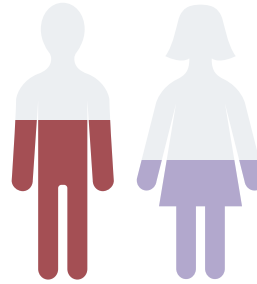
Survey Background & Overview

This report contains the results of the 2023 ESCRS Clinical Trends Survey, conducted at the 41st Congress of the ESCRS in Vienna, Austria. Delegates also had the option of taking the survey online at the ESCRS website. Questions addressed several areas of clinical practice, including general cataract surgery, astigmatism and toric IOLs, presbyopia correction, glaucoma and MIGS, and corneal refractive surgery.

More than 3,000 physicians responded to the 129 questions developed and reviewed with the ESCRS leadership team and substantiated by a data scientist. To better identify the educational needs of its members, ESCRS leadership continually refers to the results of these annual surveys and the feedback they elicit. The collected data will also enhance the opportunities featured at the Annual Congress of the ESCRS, the ESCRS Winter Meeting, and other educational channels such as EuroTimes articles and the ESCRS Education Forum online.



on key clinical opinions and practice patterns



3,173

ESCRS delegates responded to the survey

Years in Practice:

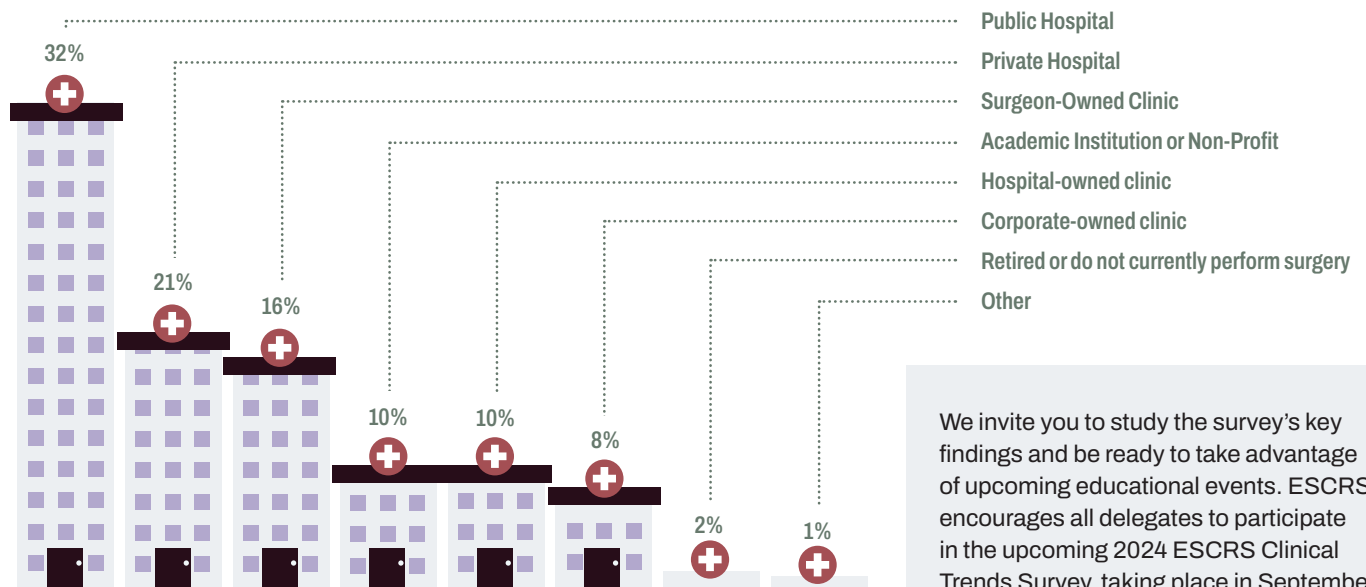


ESCRS Delegate Status:



Practice experience of 2023 ESCRS Clinical Trends Survey respondents.

Primary Surgery Locations:



We invite you to study the survey's key findings and be ready to take advantage of upcoming educational events. ESCRS encourages all delegates to participate in the upcoming 2024 ESCRS Clinical Trends Survey, taking place in September at the 42nd Congress of the ESCRS in Barcelona, and online at

<https://congress.escrs.org/congress-information/escrs-clinical-trends-survey/>



The Importance of Cataract Surgery Volume

Sorcha Ní Dhubhghaill, MBBCh, PhD, FEBOS-CR, Head of Department and Corneal and Cataract Specialist UZ Brussel

On average, respondents performed cataract surgery on 376 eyes annually, with 21% of them performing over 600 surgeries. These numbers were about where one would expect them. Surgeons need to maintain a minimum number of cases to keep their skills sharp. While it's difficult to specify an exact number, performing fewer than 300 surgeries a year might not be sufficient to maintain optimal technical capabilities.

On the other end of the distribution, I anticipate that the proportion of surgeons performing 600 or more cataract surgeries will increase due to population aging and the inevitability of cataracts with age drives the demand for high-volume clinics. In Europe, as in many other regions, there has been substantial investment in high-volume cataract surgery clinics, demonstrating a commitment to developing the infrastructure needed to meet the growing demand.

As volume and the demand for efficiency increases, the thing to remember is that we cannot compromise quality for volume/efficiency. It's not a comfort to the patient that it was quick, but it went wrong. Everything must be optimized beforehand, including equipment and a well-trained, cohesive team. Surgeons cannot simply jump into performing high volumes of surgeries without ensuring these elements are in place.

Phacoemulsification Technique

As a surgeon, I tend to adapt my technique to the case, such as using different approaches for harder versus softer lenses. However, as a teacher, I train surgeons in the divide-and-conquer method, which takes a bit more time. I am confident that surgeons can visualize everything they need with this technique, whereas chopping techniques require more depth perception and attentiveness.

The primary determinant for surgeons in choosing a technique is often what they were taught, leading to the passing down of techniques from one generation to the next. Changing techniques is challenging. If surgeons experience issues with a new technique, they often revert to their original methods, especially after an adverse event.

Understanding and customizing one's own phaco machine settings unlocks a lot of potential and prevents vulnerability to changes in machines and programs.

It's pleasing to see that ESCRS delegates are more confident in managing complex phaco cases. Understanding and customizing one's own phaco machine settings unlocks a lot of potential and prevents vulnerability to changes in machines and programs. By mastering fluidics and energy settings, surgeons can fully harness and customize their techniques, elevating their performance. This tailored approach allows them to adapt to each specific case, bringing their skills to an even higher level. It's reassuring to see that ESCRS delegates are absorbing this critical message.

Bilateral Same Day Cataract Surgery

Sixty percent of respondents do not perform bilateral same-day cataract surgery, with another 19% doing so only in extenuating circumstances. However, I expect significant changes in the next five years. In the past, same-day surgeries were avoided due to the perceived risk of infection and the need to adapt the second eye's surgery based on the first eye's outcome. Indeed, survey data showed that infection rate/risk was by far the biggest reason for not performing bilateral/same-day cataract surgery.

This perspective shifted with recent studies demonstrating that bilateral cataract surgery is safe, with minimal need for adjustments between eyes. A study by Spekreijse et al. (2023) revealed higher patient satisfaction and greater sustainability, as patients require fewer appointments. The ESCRS Survey showed that patient convenience, along with extenuating circumstances and faster visual recovery are the main reasons why surgeons performed this procedure. There are good reasons that we'll never see bilateral same-day cataract surgery performed in 100% of patients, but I expect an uptick in this procedure, especially in high-volume clinics.

The Digital Operating Room (DOR)

The survey revealed that as cataract surgery volume goes up, so too does the likelihood that a respondent will utilize a digital operating room, and I believe that interpretation of some of the benefits and barriers to DOR usage needs to be viewed through that lens.

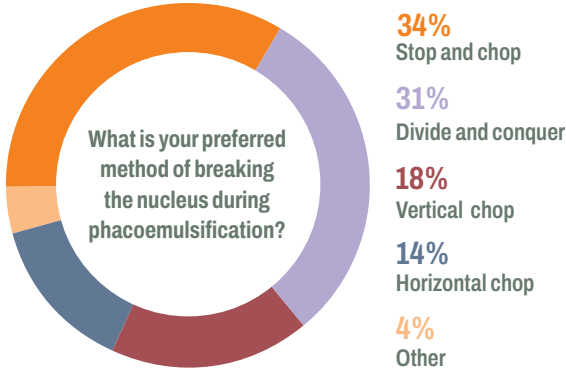
Splitting the data into two groups, low- (<600 eyes per year) and high-volume surgeons (600+ eyes per year) overall saw similar advantages to the DOR, but notably the high-volume surgeons saw much more advantage to the improved efficiency and workflow. While this is beneficial, I believe the primary advantage is traceability. From the moment you scan a patient for their lens implant biometry, you can ensure they receive the exact lens they need. After putting in all the effort to optimize the lens selection, it would be catastrophic if the patient received the wrong lens. To increase the number of patients treated, it's crucial to avoid these mistakes. Therefore, I think the DOR will be essential for high-volume surgeons.

Both high- and low-volume cataract surgeons have strong agreement on barriers, the highest of which is cost. The equipment is indeed expensive, but for high-volume clinics, the improved efficiency quickly makes the investment worthwhile. For smaller clinics the cost may remain a barrier until the price of these new technologies will come down over time. There is also a learning curve with a DOR that can be challenging, both literally and figuratively, but these challenges also diminish with time. The investment in time, money, and mental effort is significant, but once a DOR is fully operational, the process runs smoothly, without any feeling of haste, yet remains fast.

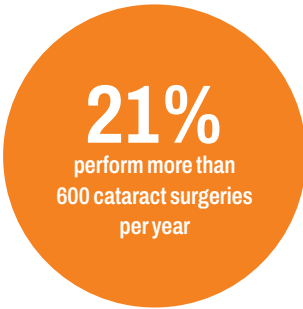
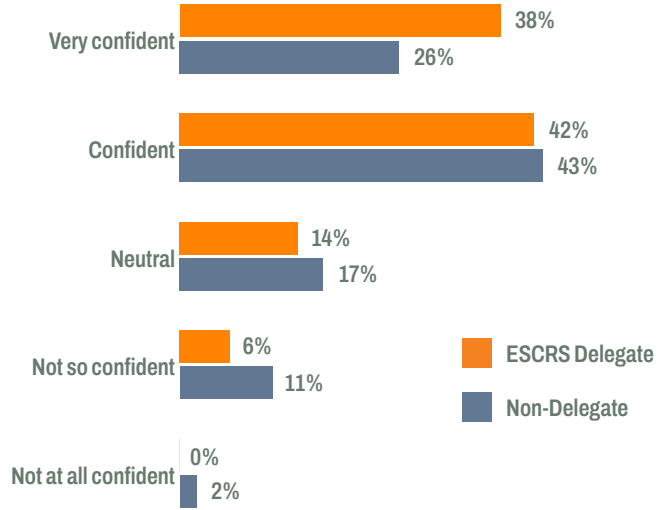
Reference

Spekreijse, L., Simons, R., Winkens, B., van den Biggelaar, F., Dirksen, C., Bartels, M., ... & Nuijts, R. (2023). Safety, effectiveness, and cost-effectiveness of immediate versus delayed sequential bilateral cataract surgery in the Netherlands (BICAT-NL study): a multicentre, non-inferiority, randomised controlled trial. *The Lancet*, 401(10392), 1951-1962.

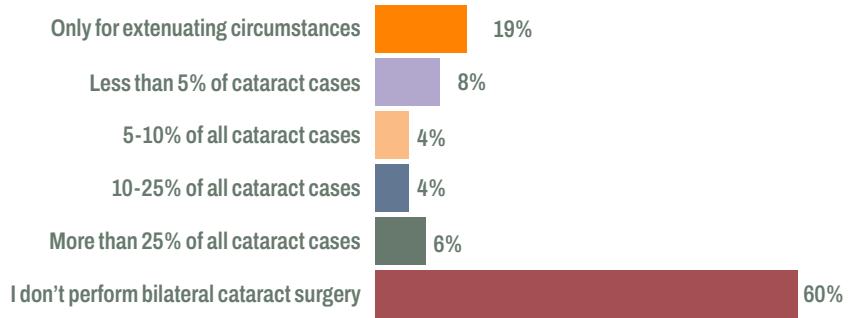
Average annual volume of cataract surgery/respondent:



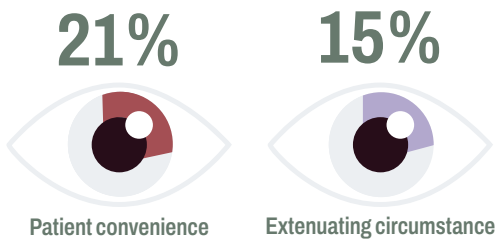
What is your current level of confidence to customize your phaco machine settings in cataract patients with more common complicated cases (i.e. small pupils, soft lenses, IFIS, and weak zonules)?



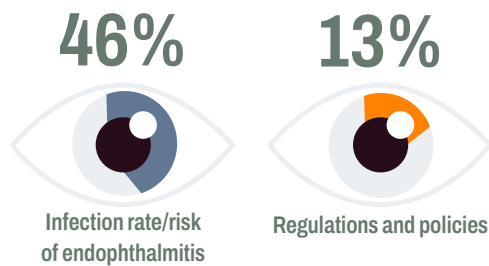
How often do you perform bilateral/same-day cataract surgery?



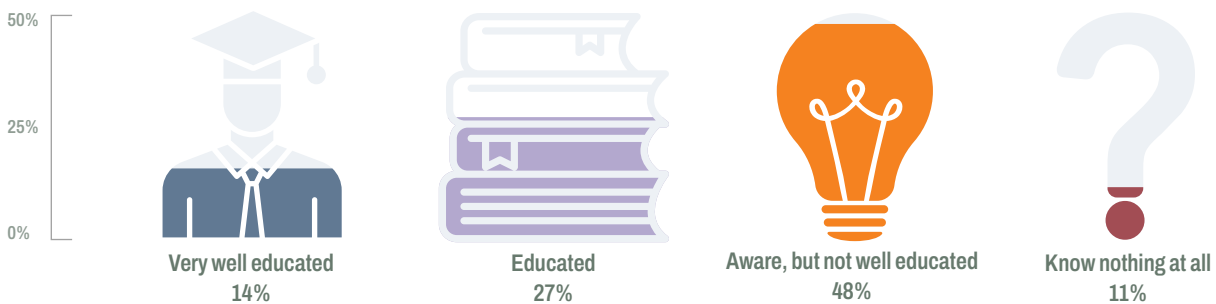
If you do perform simultaneous bilateral/same-day cataract surgery, what are your primary reasons why?



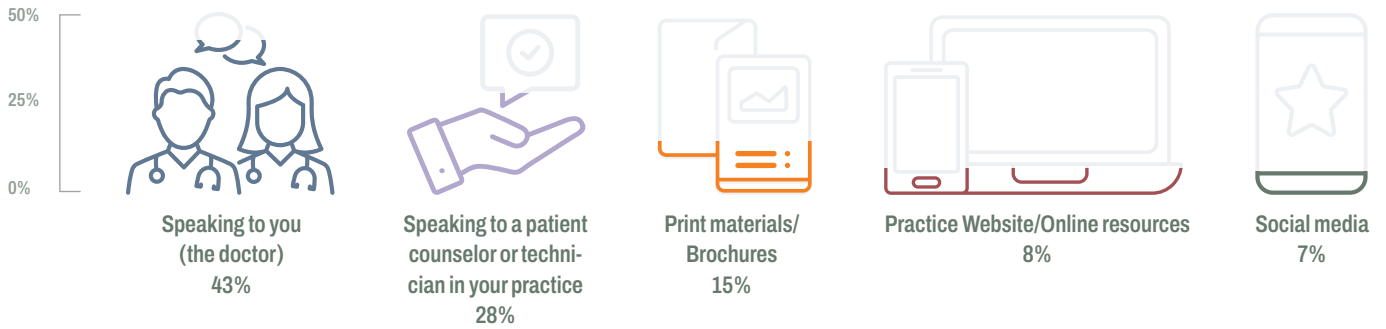
If you do not perform bilateral/same-day cataract surgery, what is your primary reason why not?



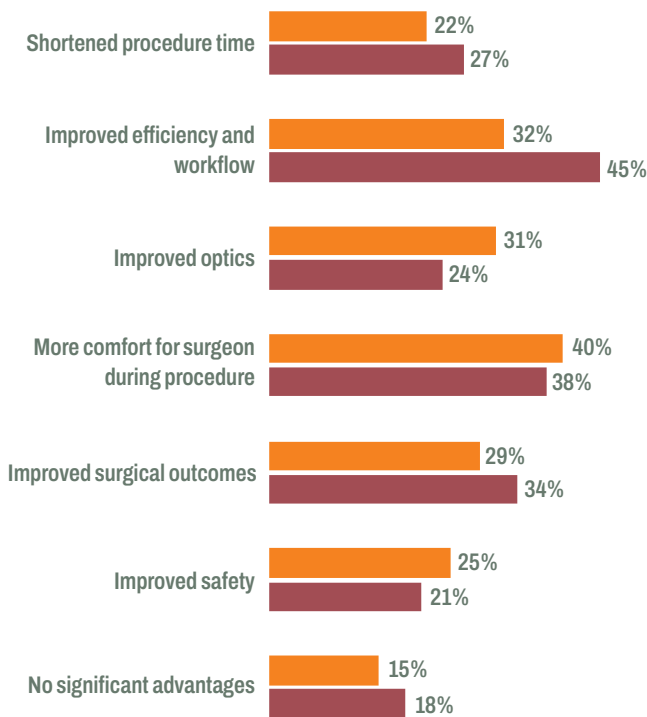
How educated are your patients on refractive IOL options when they see you in person at their initial consultation?



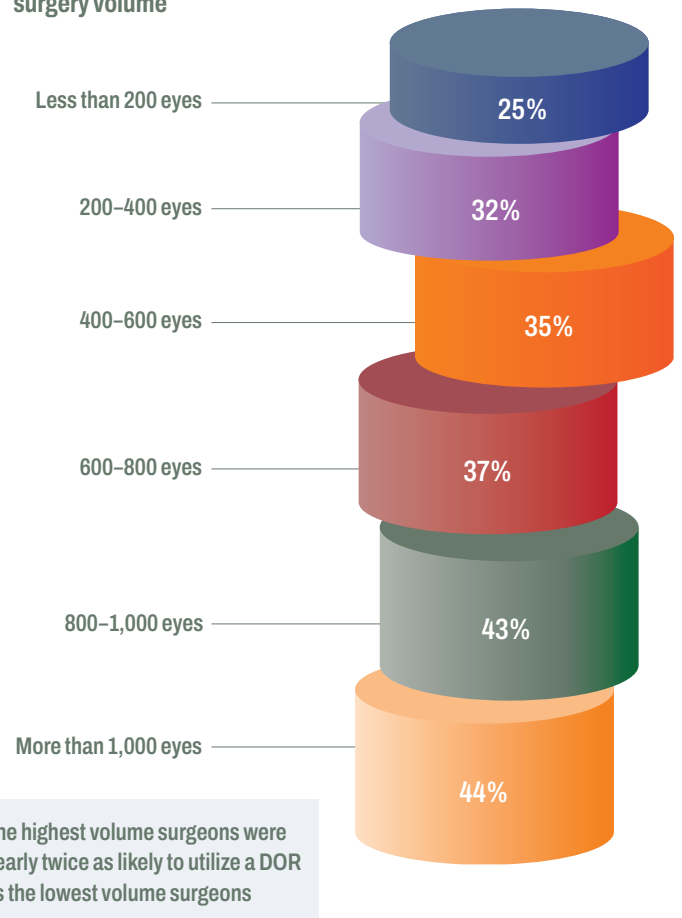
What do you consider to be the most efficient way to educate patients on refractive IOL options available to them?



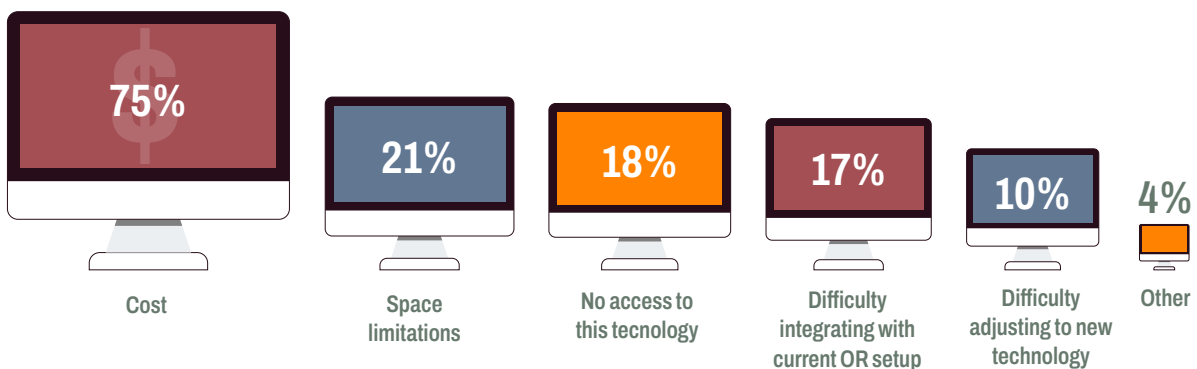
What do you believe to be the main advantages of working in a digital operating room (DOR)? (Select all that apply.)



Percent utilization of a digital operating room (DOR) by cataract surgery volume



What are the most significant barriers to integrating a digital operating room (DOR) in your practice? (Select all that apply.)



The Future of Toric IOLs

José Luis Güell, MD, PhD, Head of Corneal and Refractive Surgery Unit. Ocular Microsurgery Institute of Barcelona Grupo Miranza

According to the results of the 2023 ESCRS Clinical Trends survey, 18% of cataract procedures for patients with clinically significant astigmatism involve toric IOLs, nearly tripling the 7% reported in the 2016 survey. In my opinion, the main driver of increased toric IOLs usage is the improved understanding of these IOLs by surgeons. While cost can be a factor, especially in certain countries, the key factor is understanding the practical use and advantages of these lenses for patients. Encouragingly, we see that ESCRS delegates rate their knowledge better than non-delegates (84% vs 72%, somewhat or very good) and as knowledge and understanding increases, so too does usage.

It may take decades, but I believe this increase will continue until virtually all cataract surgeries involving astigmatism utilize toric IOLs. Unlike presbyopia, correcting or at least addressing astigmatism to some degree will always be indicated. I cannot imagine many scenarios where astigmatism is present at the time of cataract surgery, and the surgeon chooses not to correct it if they have the capability to do so.

Aligning the Intended Axis

The survey found that those who rate their knowledge of toric IOLs higher tended to use digital image registration rather than ink marking with a manual axial instrument to align the intended axis of placement for a toric IOL. While this is an

interesting observation, the available published materials do not support the superiority of one method over another. However, alignment is critical and the correction relies on it. I suspect the choice of which system to use is mostly related to individual experience and familiarity with a particular system.

Postoperative Rotational Error

The survey also asked participants how many degrees of postoperative rotational error are acceptable before visual quality and acuity are significantly impacted. While 75% of respondents indicated that 5 degrees or less is acceptable, there was some variability in responses. This reflects the reality that the acceptable degree of error depends on the resulting visual acuity. In some cases, even with a 5- or 6-degree error, uncorrected visual acuity remains very good, and residual astigmatism is low. Conversely, in other cases, a 3-degree error can induce significant residual astigmatism, leading to lower-than-expected uncorrected visual acuity. Therefore, my acceptable deviation would depend on the uncorrected visual acuity and the residual astigmatism. If the vision is not 20/20 or nearly 20/20 due to the deviation, regardless of the degree, I would consider returning to the operating room to reposition the lens. In this respect, we currently have software capabilities that are robust enough to preoperatively evaluate the effect of repositioning and design an optimal approach for doing so.

Trends in Presbyopia-Correcting IOL (PC-IOL) Usage

Nic Reus, MD, PhD, FEBOS-CR, Ophthalmologist with a subspecialty in cataract and anterior segment surgery at Amphia Hospital

Seeing the usage of PC-IOLs nearly double from 7% to 13% in the past 7 years is somewhat surprising. While PC-IOLs are attractive due to their potential for spectacle independence, many people have historically avoided them because of their side effects and costs. I believe the rise in their usage can be attributed to the increasing popularity of extended depth of focus (EDOF) lenses. Indeed, when examining presbyopia-correcting IOLs usage by different categories, the most notable trend is the growing percentage of survey respondents using EDOF lenses. This trend is also reflected in my own practice, where we began implementing the new generation non-diffractive EDOF lenses in 2020 and observed a steady increase in their use without a corresponding change in the number of multifocal IOLs being implanted.

Fitting the Right PC-IOL to the Patient

Matching patients with the right type of PC-IOL is always a function of balancing visual quality and visual function. The more spectacle independence a lens offers, the more potential issues a patient will have with dysphotopsia. At the moment trifocals still provide the best independence of spectacles and if patients are willing to tolerate some side effects, then these trifocals are beautiful IOLs.

Nevertheless, determining the right lens for a patient can be tricky. I often ask patients what their windshield looks like.

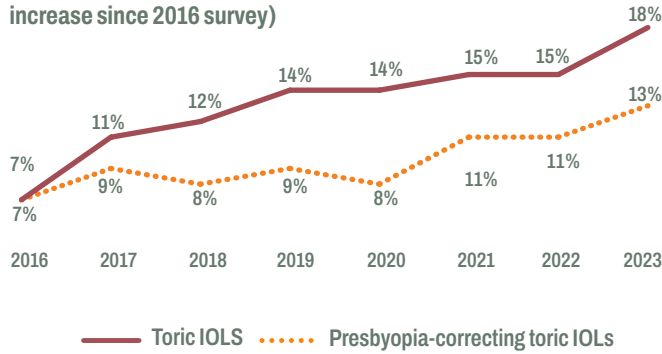
If they don't mind driving with a dirty windshield, they are likely to tolerate some visual side effects and might be excellent candidates for trifocals. Conversely, if they immediately turn on their wipers and clean the window, they'll be less tolerant of side effects, so alternative IOLs should be considered. It's also crucial to know a patient's occupation and hobbies. For example, trifocals may not be suitable for certain professions, such as taxi and lorry drivers, or may even be prohibited (e.g., commercial pilots based in Europe). These considerations help quickly assess a patient's need, personality, tolerance for side effects, and ultimately, the best lens for them.

Barriers to PC-IOL Usage

Cost is the most cited barrier to implanting more PC-IOLs. Traditionally, with older generation PC-IOLs, there was always a tradeoff: you gained visual acuity in some fields of vision but lost it in others. Patients were reluctant to pay for lenses that might worsen their vision in certain ways. However, with newer generations of PC-IOLs, this tradeoff is minimized, and I believe more patients are willing to pay out of pocket.

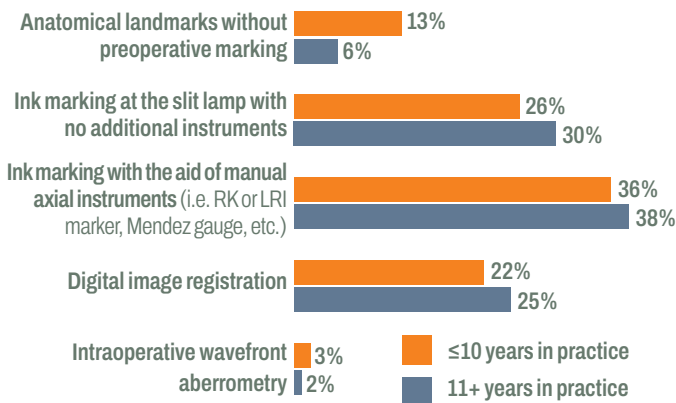
Additionally, the new generation EDOF IOLs raise less concern over nighttime quality of vision. The fact that nighttime vision concerns remain the second biggest issue (also 52% in 2020) suggests a persistent mismatch between the perception of these IOLs and their actual performance.

For patients with clinically significant astigmatism, 18% of current cataract procedures involve a toric IOL (11% point increase since 2016 survey)

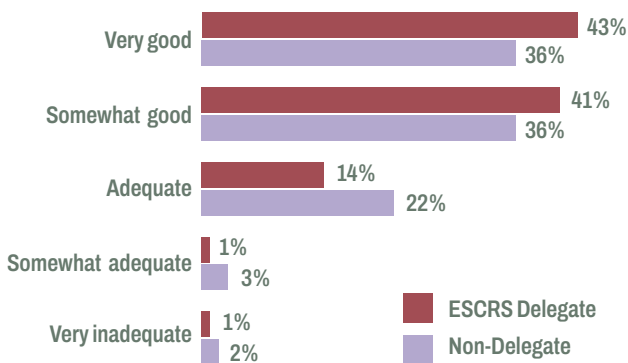


13% of current cataract procedures involve presbyopia-correcting IOLs

How do you align the intended axis of placement for a toric IOL?



How would you rate your knowledge of toric IOLs?

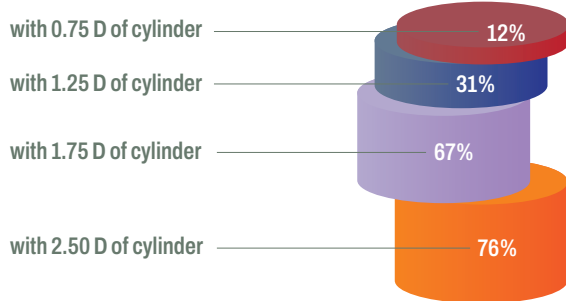


What do you believe will be the chances of a patient who has no residual refractive error and a healthy ocular surface having functionally significant visual aberrations at night...

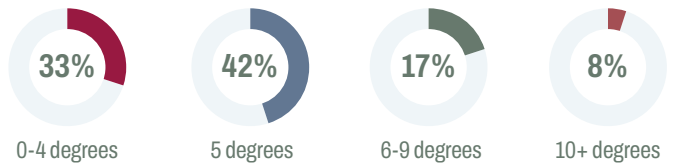
- 2.2% In a monovision patient with two monofocal IOLs
- 3.2% In an enhanced monofocal presbyopia-correcting IOL patient
- 3.8% In an EDOF presbyopia-correcting IOL patient
- 5.1% In a trifocal presbyopia-correcting IOL patient

46% of cataract patients with clinically significant astigmatism would receive a toric IOL if cost were not an issue

Percentage of respondents who implant toric IOL to manage astigmatism in a monofocal cataract patient...



After implanting a toric IOL, how many degrees of postoperative rotational error is acceptable before visual quality and degradation of visual acuity are significantly affected?



Do you consider posterior corneal astigmatism in your toric power calculation?

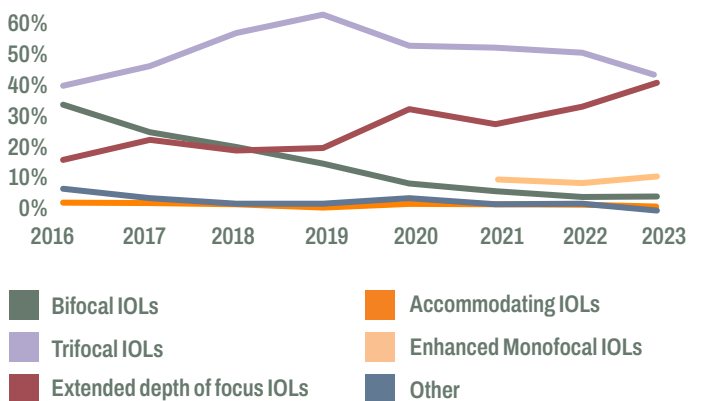


17% of current presbyopia IOL procedures are TORIC presbyopia-correcting IOLs (versus a spherical presbyopia-correcting IOL)

Biggest concerns against performing more presbyopia-correcting IOL procedures:

- 62% Cost to patient
- 52% Concern over night time quality of vision
- 39% Concern over loss of contrast visual acuity

What type of presbyopia-correcting IOL technology is used in the majority of your presbyopia correction patients?



Prevalence of Glaucoma

Roberto Bellucci, MD, Ophthalmologist at OLMA Ophthalmology

On average, respondents to the 2023 ESCRS Clinical Trends Survey estimate that 9.7% of their patients have glaucoma. This is highly consistent with the 10% prevalence in patients older than 80 years reported in the epidemiological literature. Notably, we observed a small but consistent decrease in this estimate year-over-year. The decrease is slight, at 2.3 percentage points since 2018, but it represents roughly a 20% change.

OCT has enhanced our ability to differentiate between glaucoma-related damage to the optic nerve and other types of optic nerve damage. By matching OCT results with visual field tests, we achieve better diagnoses. Therefore, improved diagnostic accuracy might be the cause of this observed decrease.

Glaucoma Treatment in the Cataract Practice

The survey found that most respondents do not perform glaucoma surgery. However, ESCRS delegates are more likely to perform glaucoma surgery compared to non-delegates (43% vs. 27%, combining glaucoma surgery and glaucoma surgery including laser procedures). This is likely because ESCRS is a society of cataract surgeons who tend to prefer comprehensive solutions, but even among surgeons, they are a minority.

So, why aren't more cataract surgeons treating glaucoma? Apart from the considerations about the cost of the procedure, treating glaucoma requires a change of pace for the cataract surgeon. Glaucoma patients need precise follow-up visits and decisive treatment decisions. Cataract is a "you can wait" disease; glaucoma is not. Adding to the complexity, patient compliance with glaucoma treatments is often poor. When treating glaucoma, a practice needs to establish a dedicated glaucoma care procedure, which can be challenging. Unlike cataract procedures, glaucoma surgery often requires the surgeon to act immediately and schedule surgery the day of or within two days after seeing the patient. Therefore, we need to adopt a different mindset for glaucoma, focusing on its unique demands rather than treating it like cataract care.

Cataract is a "you can wait" disease; glaucoma is not.

Timing of Glaucoma Surgery

The survey found that respondents were more likely to initiate laser treatment for glaucoma either as a first-line option or after initial medication, while other surgical intervention was typically considered after trying 2-3 medications. The best practice for treatment, however, depends on the type and stage of glaucoma. For example, in cases of mild-to-moderate glaucoma with minimal visual field damage and good intraocular pressure control with medication, two medications might be sufficient for a long period. However, if a third medication becomes necessary, I would consider laser or surgical intervention. On the other hand, severe or advanced glaucoma often requires

prompt surgery. I continue treating patients with medication only if their glaucoma is perfectly controlled with a maximum of two medications.

Use of Micro Invasive Glaucoma Surgery (MIGS)

The 2023 ESCRS Clinical Trends survey indicate that 16% of cataract surgery patients currently on topical therapy for glaucoma were considered candidates for MIGS. This result should be viewed through the perspective that both cataracts and glaucoma worsen over time. When performing cataract surgery, it's important to remember that intraocular pressure will decrease for a few months after the procedure but will increase again in the long term, causing problems for those patients. Thus, combining MIGS with cataract surgery can offer a better solution to consistently lower intraocular pressure in the cataract glaucoma patient without the need for another surgical procedure.

Cataract surgery is typically performed earlier now than it was years ago, and with people living longer, it is essential to address glaucoma at the time of cataract surgery. As we know, glaucoma eye drops that significantly decrease intraocular pressure are unfortunately often not well tolerated, and surgically eliminating the need for glaucoma medications would be beneficial to the patient, especially in the long run. Thus, while 16% of cataract surgery patients on topical glaucoma therapy are considered good candidates for MIGS is a reasonable amount, we should probably aim even higher.

I predict that, not only will there be an increase in glaucoma cataract patients viewed as MIGS candidates, but there will be significantly more cataract surgeons performing MIGS in the future. Patients who are aware of their glaucoma will ask for a single surgical session and those who are unaware will hardly understand the need for a second surgery or might think something went wrong the first time. So, for those reasons, I believe that more cataract surgeons will be performing surgical treatments for glaucoma in the near future.

Building Confidence with MIGS

Overall, only 26% of respondents felt confident in performing MIGS. When examining the disaggregated data, confidence levels were 11% among those who do not perform MIGS, 62% among those who perform MIGS in a minority of their cataract patients with glaucoma, and 73% among those who perform MIGS in a majority of their cataract patients with glaucoma.

Comfort with the procedure itself is likely only one factor. Postoperative issues such as hypotony, choroidal detachment, and late failure can be challenging to manage. While glaucoma surgery is not reserved for super specialists and every surgeon can learn it, it is more demanding compared to cataract procedures which are relatively uniform. However, with further training, new devices for easier diagnosis and simpler follow-up, surgeons will become more confident in performing glaucoma surgery, leading to an increase in the number of MIGS procedures.

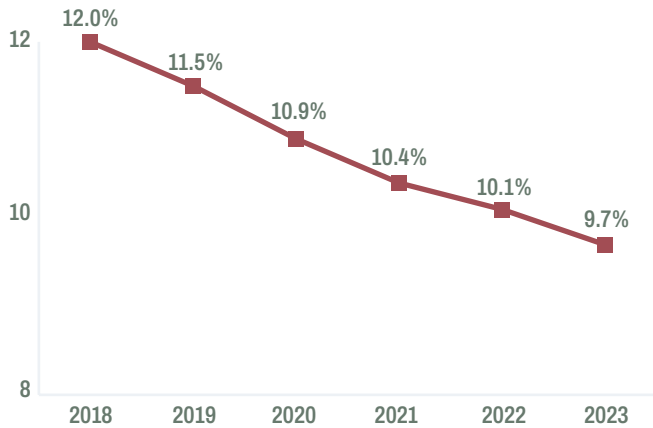


26 average number of patients seen each month that are considered as having glaucoma

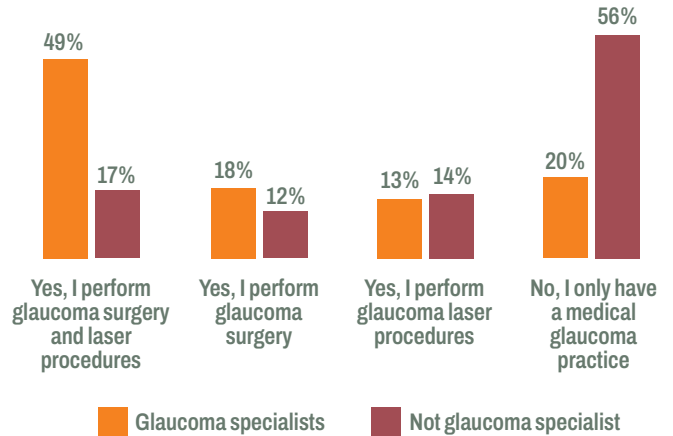


16% of cataract surgery patients, currently on topical therapy for glaucoma, are candidates for a minimally invasive glaucoma surgery (MIGS) device

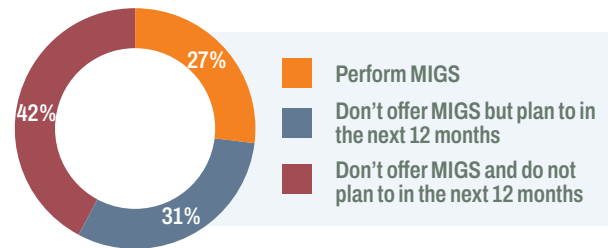
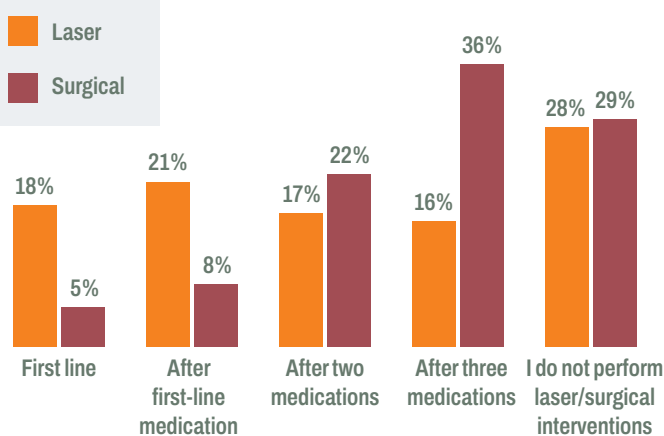
What percentage of ALL your cataract patients would you estimate have glaucoma?



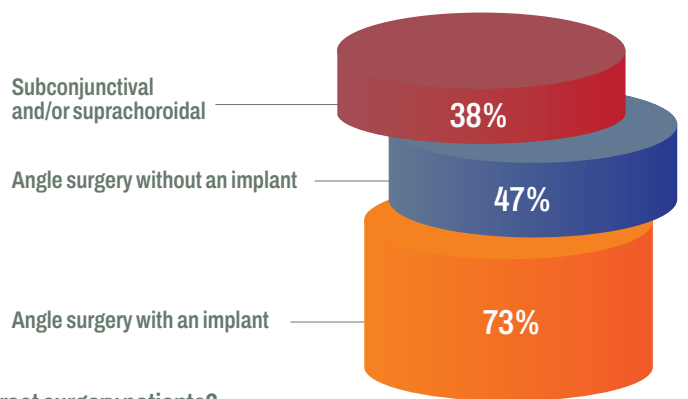
Do you perform any glaucoma surgery (including MIGS) or laser procedures?



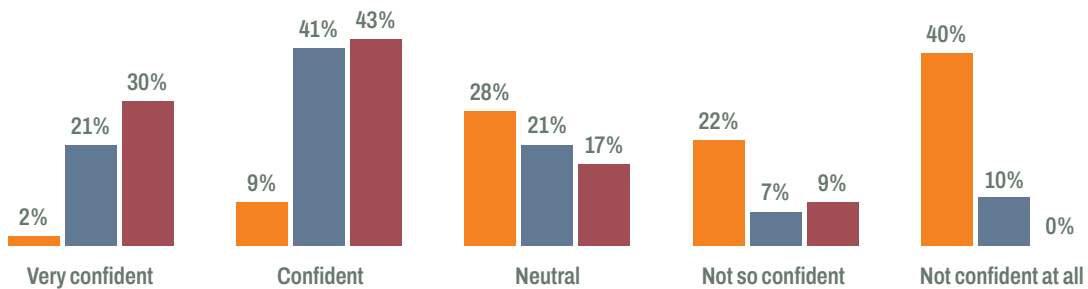
When do you usually initiate intervention for your glaucoma patients?



Which MIGS procedure do you perform? (select all that apply)



What is your confidence level in performing MIGS procedures on cataract surgery patients?



■ Don't perform MIGS
 ■ Perform MIGS in less than 50% of cataract patients
 ■ Perform MIGS in more than 50% of cataract patients

Utilization of Refractive Procedures

Andreia Rosa, MD, PhD, Ophthalmologist at University Hospital of Coimbra, Portugal

While standard ablations are the most common corneal refractive procedure, surprisingly 17% of respondents use topography-customized treatments for a majority of their procedures. This method imports topography from a laser-compatible system to address corneal irregularities beyond refractive errors, potentially leading to better results. However, the technology isn't fully developed to realize all its benefits, making the 17% usage rate unexpectedly high. In comparison, wavefront-optimized treatments, which are simpler and widely used, have a similar rate of 19%.

Femtosecond intrastromal lenticular extraction (KLEx) is a lesser-used procedure. Its top three perceived advantages over other refractive procedures are an improved postoperative ocular surface, lower incidence of dry eye, and better biomechanical corneal stability. However, current research hasn't fully confirmed enhanced biomechanical stability with KLEx. Studies suggest the rate of ectasia may be similar between KLEx and LASIK, though it's a very rare complication in both.

Examining and Managing the Ocular Surface

The ESCRS Clinical Trends Survey revealed that a higher percentage of doctors routinely check the ocular surface in all refractive surgery cases (59%) compared to cataract surgery cases (48%). As the expectations for cataract surgery are nearly as high as those for refractive surgery, a thorough ocular surface examination should be performed in all cases, whether it's cataract or refractive surgery.

Moreover, it's crucial to not only perform the inspection but also to look for the correct indicators. Doctors should seek to identify signs of blepharitis and meibomian gland dysfunction. Additionally, assessments of tear stability and volume, such as using tools as tear breakup time and Schirmer's test, respectively, should be included in the evaluation.

I was encouraged to see that most respondents were likely to postpone surgery in a patient with moderate dry eye until the dry eye is better managed, and ESCRS delegates are even more likely than non-delegates to postpone. Delaying surgery until the ocular surface is better managed may risk losing the patient if they decide not to return, but the benefits of waiting far outweigh this concern. Surgical outcomes won't be as successful if the ocular surface is not optimal. The refraction measurements may be inaccurate and there might be a certain amount of irregular astigmatism that cannot be properly corrected. Additionally, there is a higher likelihood of more severe dry eye post-surgery.

Postponing surgery to improve the ocular surface minimizes these risks. It ensures a more precise preoperative examination and reduces postoperative complaints. Many patients achieve 20/20 vision but still feel uncomfortable due to dry eye or surface issues. The doctor is happy, but the patient is not. It's crucial to manage dry eye meticulously, as some patients may have significant discomfort without obvious signs like staining (i.e. "pain without stain"). Therefore, delaying surgery for better ocular surface health generally leads to better outcomes and greater patient satisfaction.

Detecting Irregular or Weakened Corneas

A wide variety of tools, particularly topography and slit lamp, are used to diagnose corneal irregularities. Detecting these issues before refractive or cataract procedures is crucial. Irregular corneas may have temporary irregular astigmatism, like from dry eye, or biomechanical problems such as keratoconus or pellucid marginal degeneration. These conditions are classic contraindications for laser ablations due to the risk of iatrogenic ectasia. Similar issues arise in cataract surgery, where untreated corneal irregularities can compromise outcomes. Thus, accurately diagnosing and understanding the corneal condition is essential before any surgical intervention.

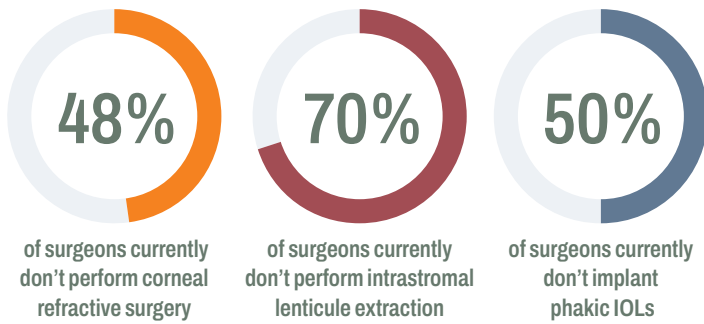
Fortunately, a majority of both ESCRS delegates and non-delegates are confident in their ability to detect abnormal, irregular, or weakened corneas. However, the proportion of those who are very confident is higher among delegates (31% vs 20%). This difference may be attributed to the strong educational efforts of the ESCRS. ESCRS offers numerous symposia and educational/diagnostic courses on patient selection. To improve confidence in detecting irregular corneas, it's crucial for everyone to participate in educational activities, whether online, at congresses, or through literature. Learning from colleagues is also essential to building confidence.

To improve confidence in detecting irregular corneas, it's crucial for everyone to participate in educational activities, whether online, at congresses, or through literature.

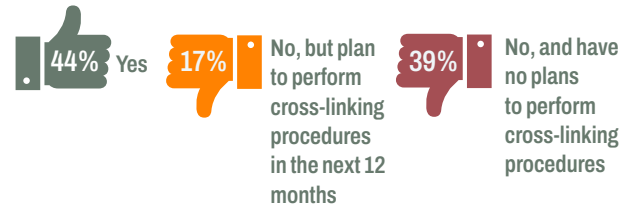
Phakic IOLs

While only 50% respondents implant phakic IOLs, 66% foresee their use of phakic IOLs increasing so we may see this number rise in the coming years. One driver of the expected increase in phakic IOLs may simply be that they are getting better, and they are easy to integrate into one's practice without the need for new expensive equipment. The main advantages of phakic IOLs, according to respondents, are the preservation of corneal tissue and the removability/reversibility. Indeed, preserving corneal tissue is a significant benefit. However, the removability or reversibility is more complicated. Some publications have shown that even after removing phakic IOLs, there is still a notable decrease in endothelial cell density indicating that simply removing the lenses does not eliminate the impact on endothelial cells.

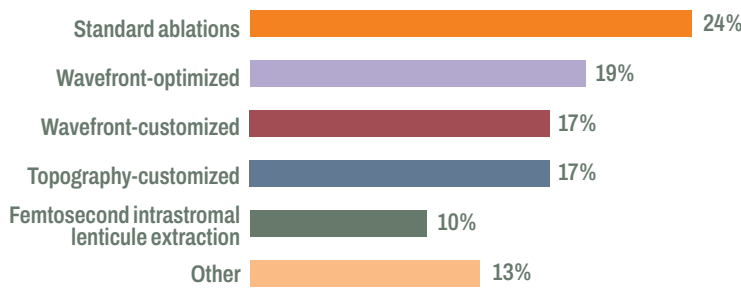
Overall, while we should be optimistic about the future of phakic IOLs, we must always apply caution with any new medical technology.



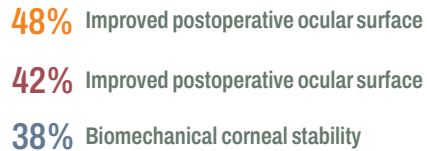
Are you currently performing corneal collagen cross-linking?



What category are the majority of your corneal refractive procedures CURRENTLY?



Top 3 believed benefits of intrastromal lenticule extraction over another refractive procedure.



* respondents were able to select multiple among 8 options

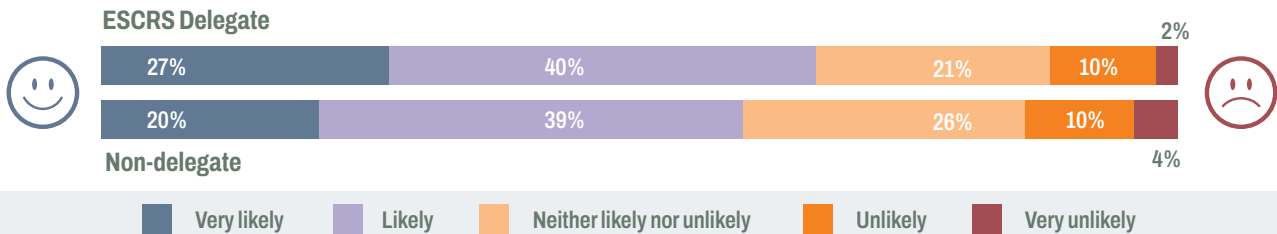
What are the primary 2 reasons you are not implanting phakic IOLs?



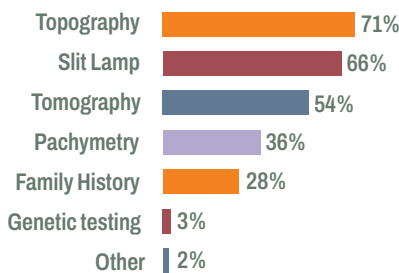
What do you believe to be the primary 2 advantages of phakic IOLs compared to other refractive procedures?



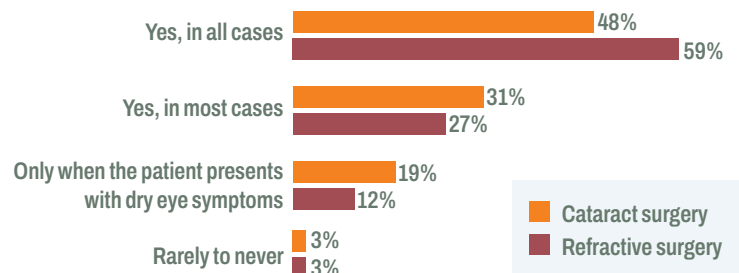
How likely are you to postpone surgery in a patient with moderate dry eye until the dry eye is better managed?



What do you use to diagnose corneal irregularities? (Select all that apply.)



Are you systematically checking the ocular surface in your preoperative laser vision correction/ cataract surgery examination?



How confident are you in your ability to detect abnormal, irregular or weakened corneas?



Contributors to this Issue

The Importance of Cataract Surgery Volume (p.3)



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The Future of Toric IOLs (p.6)



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Trends in Presbyopia-Correcting IOL (PC-IOL) Usage (p.6)



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Prevalence of Glaucoma (p.8)



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Utilization of Refractive Procedures (p.10)



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