

by C.M. Wavikar, DOMS

Participants



C.M. Wavikar, DOMS



Paul Hughes, M.D.



Jodhbir Mehta,
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Julian Theng,
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Han-Bor Fam, M.D.



V.C. Mehta, M.S.

There is a notion worldwide that Asian children respect and obey elders to a degree unrivaled by Western children. While that may be true, sometimes Asian children know better than their parents.

A case in point: I get a lot of email queries from my patients' children. These children often are being educated in the United States and ask questions on behalf of their parents, who are about to undergo cataract surgery. After these children are told of some helpful websites to visit, they peruse the details of intraocular lenses and other surgical modalities, and then help their parents make informed decisions.

My colleague, **Jodhbir Mehta, M.D., FRCS**, Consultant, Cornea, External Disease and Surgery, Singapore National Eye Centre, Singapore, has a similar experience with patients and their children.

"I think you have two tiers of people—people whose children are on the Internet and find a lot of information. These people often bring their children to clinics," Dr. Mehta says. "They will ask specifically, 'What about this lens?'"

Dr. Mehta notes an older generation also exists in Singapore without family nearby, who rely on the clinical staff to educate them about lens specifics.

Whatever the case may be—whether you have "informed" patients coming in or have to do some extra education in the hospital—it's important that ultimately all patients understand the value that today's IOLs bring to the table.

We have plenty of experience with the AcrySof Toric lens (Alcon, Fort Worth, Texas), a premium lens for cataract patients with astigmatism. Of 114 IOLs implanted, 94% of patients achieved spectacle independence, and the vast majority only have 0 to 0.25 D of residual cylinder one week post-op.

This is good news for Indian patients because about 30 to 40% of them can benefit from toric IOLs.

Unfortunately, we are performing far fewer toric implantations than possible in

a more perfect world. This could conceivably be a result of Indian patients not being prepared to spend adequately for healthcare.

Although financial implications will continue to play a role in healthcare decisions in Asia, we have the responsibility to educate our patients to make good decisions for their vision, which ultimately may help to convert more into premium IOL users. It's good to have help from the children, but we also need to do better.

In India, patients have more faith in doctors than in advertisements. Therefore, it is critical to provide adequate one-on-one counseling, citing the benefits and reliability of modern cataract surgery technology.

Dr. Mehta notes that in Singapore, hospitals run free public eye education sessions. These are excellent venues for explanations about cataracts, cataract surgery, and IOL technology. Free eye exams and educational talks are also provided. One session may draw nearly 1,000 visitors.

I'd like to commend Singapore on this creative method of teaching. According to Dr. Mehta, even in this developed nation patients often still present quite late for cataract surgery.

It takes time to understand platform of premium IOLs available, which will be explained in large part by this *EyeWorld* supplement, from toric to multifocal IOLs. But once physicians understand, it is naturally easier to explain to patients. The results are rewarding, both for the physician and the patient.

Editors' note: Dr. Wavikar is in private practice, Dr. Wavikar's Eye Hospital, Maharashtra, India.

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Improved vision for common daily tasks

Surgeon says tasks such as using a computer are made easier with AcrySof IQ ReSTOR

Paul Hughes, M.D., Medical Director, Vision Eye Institute Southline, Australia, is a very experienced user of the AcrySof IQ ReSTOR +3.0 D multifocal IOL (Alcon, Fort Worth, Texas). “It’s my number one lens choice for refractive lens exchange patients,” Dr. Hughes said.

Dr. Hughes isn’t in the business of talking up technology to make a quick buck, overpromising to patients and under-delivering. He is very practical, eschewing terms like “reading vision” for terms like “functional near vision” that better convey how patients really see.

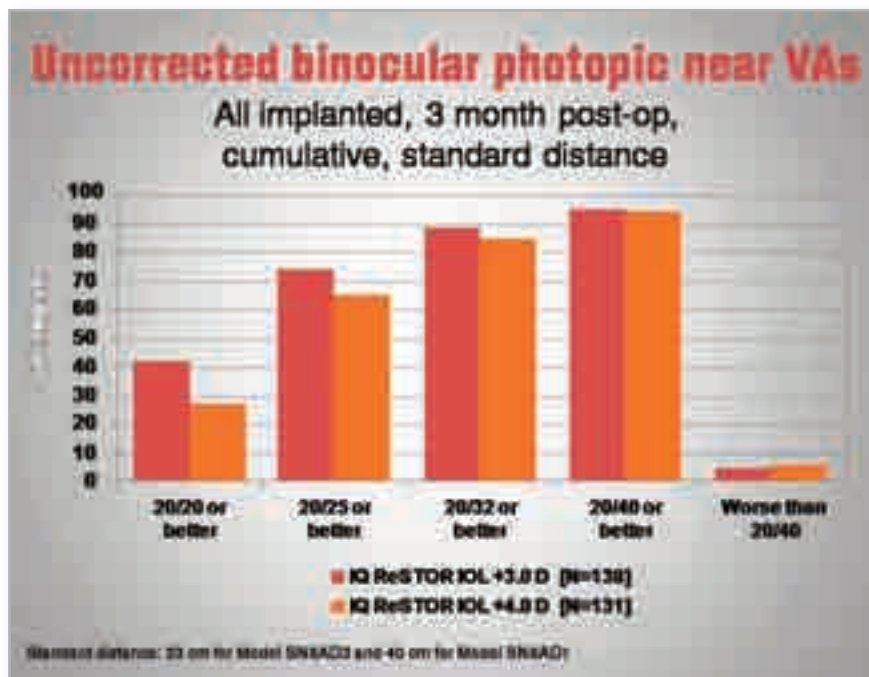
“I talk about functional near vision,” Dr. Hughes said. “In this world we live in, you want to read a cell phone, see food on your plate, and see the computer.”

When talking to patients, Dr. Hughes assesses what patients want to be able to see and educates them on what he can offer and why.

Today, he’s convinced that the best he can offer presbyopic patients is the AcrySof IQ ReSTOR +3.0 IOL. He believes it provides the best range of

“It’s my number one lens choice for refractive lens exchange patients”

Paul Hughes, M.D.



As good as uncorrected near visual acuity is with the AcrySof IQ ReSTOR +4.0 D IOL, it’s even better after implantation of the AcrySof IQ ReSTOR+3.0 D IOL

Source: Paul Hughes, M.D.

vision—distance, intermediate, and functional near vision—without the negative photic phenomenon that often accompanies other lenses.

Dr. Hughes uses a questionnaire to determine each patient needs. If they want to be spectacle independent, Dr. Hughes opts for the AcrySof ReSTOR +3.0 D IOL in the dominant eye first.

“We wait a week between surgical dates to hear the patient’s response to near vision,” Dr. Hughes said. Ninety-eight percent of the time, Dr. Hughes implants the same IOL in the fellow eye. If for some reason near vision is not as sharp as a patient is comfortable with, he opts for an AcrySof ReSTOR +4.0 D IOL in the second eye.

“It’s the fact that the ReSTOR +4.0 reading addition is slightly stronger,” Dr. Hughes said. “The near point is closer. Still, I find with neuroadaptation, bilateral implantation of the ReSTOR +3.0 D IOL is

best in the majority of my patients.”

Dr. Hughes noticed something interesting about why more presbyopic patients are opting for bilateral ReSTOR +3.0 D IOLs. Before cataract surgery, as people gradually become more presbyopic, they have to extend their arms to read more clearly. The ReSTOR +4.0 D IOL allows them to read clearly, but at closer distances than they are used to.

Now, with the ReSTOR +3.0 D IOL, patients prefer to read at distances they have become comfortable with. This is a credit to the ReSTOR +3.0 D IOL’s functional near vision performance, according to Dr. Hughes.

Meanwhile, distance vision is excellent with both the ReSTOR +3.0 D and +4.0 D IOLs, Dr. Hughes said. Intermediate vision also is improved tremendously with the ReSTOR +3.0 D IOL.

“A big factor is being able to read a computer screen.

Patients are going to be able to do this with the ReSTOR +3.0 D lens,” Dr. Hughes said. “Everyone today, even the geriatric population, uses the Internet. Seeing a speedometer in the car is also very important. That’s the intermediate world that we live in.”

Some competitor multifocal lenses don’t offer clear intermediate vision, while others have to make drastic compromises on photic phenomenon.

The AcrySof IQ ReSTOR +3.0 D multifocal IOL is different.

The apodized design of the lens is one reason for the reduction of glare and halos. “Apodization is key,” Dr. Hughes said. “You have circular rings in the central 3.6 mm of the lens. It’s the circular areas that traditionally give rise to these phenomenon. But with the ReSTOR lens, the ring step heights are progressively smaller from the center to the periphery. This reduces the circles of blur at the focal point of the eye and reduces halos and glare.”

The number of rings in this central portion is reduced from 11 to 9 with the ReSTOR +3.0 D IOL, which helps reduce the incidence of glare and halos, Dr. Hughes said.

“The ReSTOR +3.0 D lens is a fantastic technology,” Dr. Hughes said.

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Surgeons pleased with features, ease of implantation of AcrySof IQ ReSTOR +3.0 D

Julian Theng, MBBS, FRCS, FRCOphth, Medical Director, Eagle Eye Center, Mount Alvernia Hospital, Singapore, distinctly remembers when the AcrySof IQ ReSTOR +4.0 D multifocal IOL (Alcon, Fort Worth, Texas) was unleashed in his nation. "There was a wow factor," Dr. Theng recalls. "Visual quality was excellent for distance intermediate and near."

There was room for improvement in intermediate vision, and that's why Dr. Theng now likes the AcrySof IQ ReSTOR + 3.0 D IOL so much. "In terms of intermediate distance, the +3.0 D lens seems to be ideal in this day and age where most people use computers," Dr. Theng said.

In Dr. Theng's opinion, the +3.0 D lens offers a major improvement in intermediate vision, especially over competitor lenses in which such visual range comes at the expense of side effects like halos and glare.

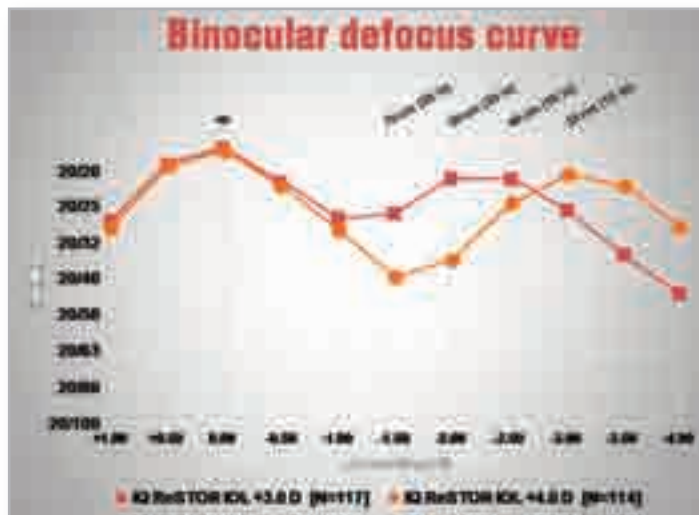
"Although I did try [competitor lenses] for some patients, I didn't find them fitting nicely into my practice," Dr. Theng said. "There were quite a few complaints from patients."

Near vision has not suffered at the expense of additional intermediate vision, Dr. Theng said. "We notice the +3.0 D IOL provides near vision that seems to be sufficient for most patients," Dr. Theng said. "For common reading, it's the ideal lens."

Only about 5 to 10% of Dr. Theng's multifocal implant patients feel they need to see a bit closer than the near vision

“There was a wow factor. Visual quality was excellent for distance, intermediate and near”

Julian Theng, MBBS, FRCS, FRCOphth



Two sinusoidal curves with the AcrySof IQ ReSTOR +3.0 D IOL showing a shift to the right and improved intermediate vision

Source: Paul Hughes, M.D.

provided by the +3.0 D lens. In those cases, Dr. Theng opts for the +4.0 D IOL. Those who enjoy sewing or needle work are examples of people who might benefit from the strategy of +3.0 D in one eye and +4.0 D in the second, he said.

V.C. Mehta, M.S., Mehta Eye Clinic, Mumbai, India, has similar views about the AcrySof IQ ReSTOR +3.0 D and +4.0 D IOLs.

"When we were using the ReSTOR +4.0 D IOL, the near vision was good very close to the eye," Dr. V.C. Mehta said. "When we started using the ReSTOR +3.0 D IOL, this near point receded a little bit."

The result was that Dr. V.C. Mehta could better tailor the IOLs to his patients' visual needs. Executives working extensively on computers would benefit more from the ReSTOR +3.0 D IOL, while an elderly man with a reading hobby likely would enjoy the ReSTOR +4.0 D IOL better, Dr. V.C. Mehta said.

"Now with the ReSTOR +3.0 D IOL, we have an option of finding out what kind of lifestyle our patient has and offering them either the ReSTOR +3.0 D IOL or the

ReSTOR +4.0 D IOL. What is remarkable is that by giving up some slightly closer vision with the ReSTOR +3.0, the patient gains significant benefit in intermediate performance. A full range of vision finally delivers on the promise of presbyopic correction," Dr. V.C. Mehta said.

The nice thing about Alcon refractive lens exchange products, Dr. Theng said, is that the IOLs can complement one another, and the insertion technology is seamless, he said.

Han-Bor Fam, M.D., Senior Consultant and Head of The Cataract and Implant Service, NHG Eye Institute, Singapore, agreed. He said Alcon's D cartridge injector can insert a variety of IOLs, from multifocal to toric, which simplifies surgery.

Dr. Fam advocates injecting such lenses through 2.2-mm micro incisions. "Previously we used incisions as big as 2.75 mm," Dr. Fam said. "But today with the D cartridge, we can inject safely, smoothly, and efficiently with 2.2-mm incisions. It might seem like splitting hairs, but 2.75 mm is almost half a millimeter larger. With the 2.2-mm incision, visual rehabilitation is faster because there's less distortion to the wound."

Jodhbir Mehta, M.D., FRCS, Consultant, Cornea, External Disease and Refractive Surgery, Singapore National Eye Centre, Singapore, said that the AcrySof lenses are implanted in a similar fashion, with a few minor exceptions.

"The only thing you need to be aware of is axis rotation when placing a toric lens in the capsular bag," Dr. Mehta said.

But because the AcrySof platform does not incorporate many changes from lens to lens, surgeons can feel comfortable trying new technologies, Dr. Mehta said. "When doctors shift to new techniques, the less you change, the better," Dr. Mehta said.

The biocompatibility of the AcrySof lenses is a boon for patients, who experience a resulting lower posterior capsule opacification rate, Dr. Mehta said. Published literature has reported 6% of eyes require Nd:YAG capsulotomy after one year, a lower rate than with other foldable acrylic, PMMA, or silicone IOLs.

The AcrySof lens haptics also come "quite folded over," Dr. Mehta said, and unlike other rigid lenses, don't carry the same risk of breaking the capsule.

"The AcrySof material has been well tried and tested for many years," Dr. Theng said.

In fact, the material has been specifically designed for use in the eye and therefore works much better than other materials, Dr. V.C. Mehta said.

"It's highly biocompatible," Dr. V.C. Mehta said. "Stability and decentration issues are minimal, and PCO has proven to be much lower with this design and material."

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Working toward glasses-free vision at all distances

Surgeons say AcrySof IQ ReSTOR +3.0 D is making this possible

Over the last two years, **C.M. Wavikar, DOMS**, in private practice, Dr. Wavikar's Eye Hospital, has noticed a large increase in patients' visual needs at his clinic in Maharashtra, India.

"Patients' visual needs have definitely gone up," Dr. Wavikar said. "Patients themselves come in asking for better quality of vision. They want to be independent of glasses."

Dr. Wavikar is more than happy to educate patients about their increasingly excellent options, thanks to modern cataract surgery. "We tell them that basically, there are four parts to the range of vision," Dr. Wavikar said. "There is distance, which is used for driving, intermediate distance, used for TV viewing, near intermediate for computer usage, and near vision for reading. Normally, out of these four parts of the range of vision, patients want at least two."

Traditionally, after being implanted with a multifocal lens, patients may not have required glasses for distance and reading vision, but they may have needed glasses to see the TV or computer. Given the advances in IOL technology, that is changing.

"With the AcrySof IQ ReSTOR +3.0 D multifocal

"The +3.0 D IOL is a superb lens. It has the best satisfaction rate of all the lenses I've implanted"

Julian Theng, MBBS, FRCS, FRCOphth

IOLs [Alcon, Fort Worth, Texas], we are trying to make vision glasses-free for all four parts of vision," Dr. Wavikar said. "It is working. Patients are quite comfortable visually."

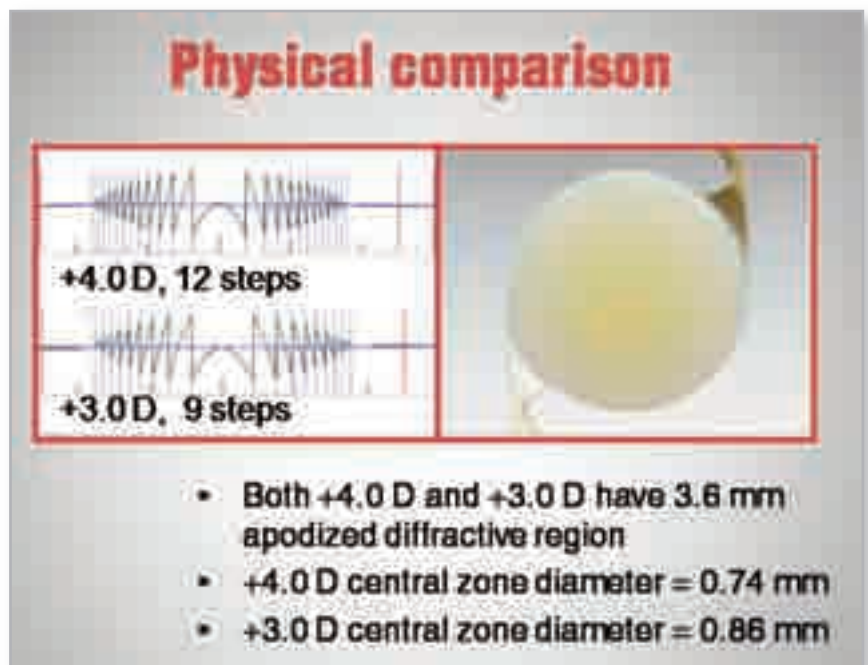
The lens, for instance, works much better for computer users. "Basically when you add +3.0 D at the spectacle plane, it works, slightly undercorrecting near vision, so it acts well for the computer screen," Dr. Wavikar said.

Dr. Wavikar also believes neuroadaptation is faster with the +3.0 D IOL, although he doesn't have a good scientific explanation for this.

Meanwhile, **Julian Theng, MBBS, FRCS, FRCOphth**, medical director, Eagle Eye Center, Mount Alvernia Hospital, Singapore, has a lot of compelling data on the AcrySof ReSTOR +3.0 D IOL. He looked at a group of 19 highly motivated Chinese patients looking for a cure for presbyopia. They no longer wanted to put up with glasses.

Post-operative uncorrected vision turned out to be just what these patients were looking for. UCVA was better than 20/40 on average at near and intermediate distances simultaneously six months post-op. Further, subjective questionnaires found that 80% of patients had no difficulty or minimal difficulty with activities like reading, shaving, applying makeup, using a computer, or using a cell phone. No patient had severe difficulty with any daily life activities.

"The +3.0 D IOL is a superb lens," Dr. Theng said. "It



Comparing AcrySof IQ ReSTOR +3.0 D and +4.0 D IOLs

Source: Paul Hughes, M.D.

has the best satisfaction rate of all the lenses I've implanted." The average satisfaction rate was 8 out of a possible score of 10.

If a patient needs to see closer than what the ReSTOR +3.0 IOL can provide, Dr. Theng said a good option is to implant a +3.0 D lens in one eye and an AcrySof IQ ReSTOR +4.0 D lens (Alcon) in the other eye.

"These are odd cases for people who need to bring things closer, like watch makers," Dr. Theng said.

The ReSTOR lens, meanwhile, largely leaves behind the problems of halos and glare, Dr. Theng said.

At six months post-op, 50% of the patients Dr. Theng studied had no difficulty or minimal difficulty with halo, and 45% of patients had only moderate difficulty with halo. For glare, 70% of patients had no difficulty or minimal difficulty, and 30% of patients had only moderate difficulty.

According to Dr. Theng, the IQ ReSTOR +3.0 D lens' night vision symptoms were much less significant than not

only other versions of the ReSTOR, but other lenses as well.

"I suspect some of these patients who were not completely satisfied with the lens may have had very mild cases of posterior capsule opacification," Dr. Theng said. "It may have made their visual symptoms seem more dramatic or affected their visual quality."

Patients are eager for premium IOLs like the +3.0 D lens at Dr. Wavikar's Eye Hospital.

"Basically the global recession has not hit the ground level in India," Dr. Wavikar said. "For us, as far as the cataract surgeon is concerned, there's not much downward turn."

The upward mobility of Indian patients combined with superior cataract surgery technology is bringing the country's bright future into clear focus indeed.

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Physicians, patients in India and Singapore discovering benefits of premium IOLs

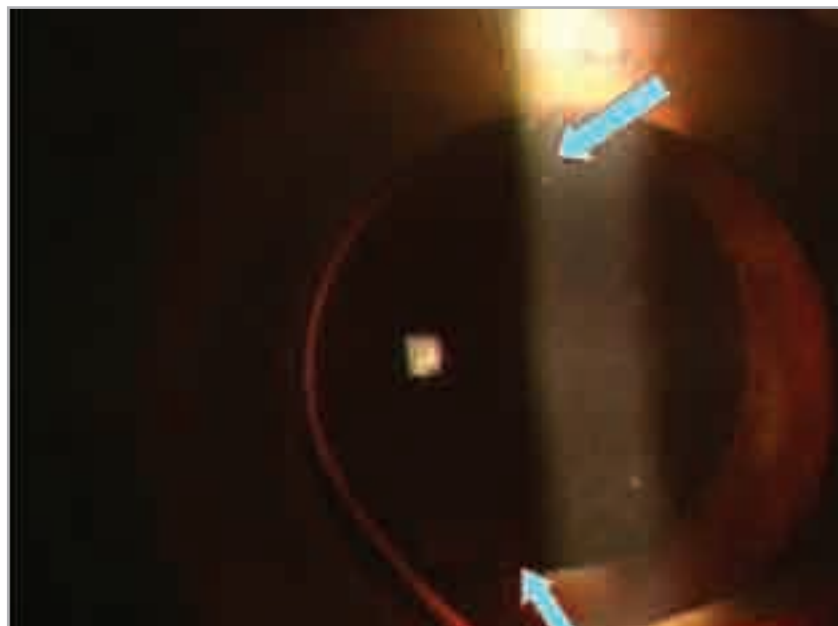
Singapore is one of Asia's, and the world's, most developed nations. Its population is also aging. "Every one of our seniors will want to solve reading problems," said **Julian Theng, MBBS, FRCS, FRCOphth**, medical director, Eagle Eye Center, Mount Alvernia Hospital, Singapore. "We also have quite a few patients with astigmatism who need correction."

Whether or not Singaporeans can afford cataract surgery with premium IOLs shouldn't be much different than in the developed West. "They're quite happy to ask for the best lens for them" and pay for it out of pocket, Dr. Theng said.

Not all parts of Asia are so well off. As **C.M. Wavikar, DOMS**, mentioned in his introduction to this article series, patients have not been prepared to spend adequately on healthcare needs, although times are changing as the ranks of upwardly mobile citizens swell.

One thing is for sure: The need in both India and Singapore for astigmatism-correcting IOLs is high.

Thirty to forty percent of cataract surgery patients in India can benefit from a toric



Dilating patients on post-op day one will allow surgeons to check the axis orientation of the AcrySof Toric IOL

IOL, Dr. Wavikar said. Similarly, **Han-Bor Fam, M.D.**, Senior Consultant and head of the cataract and implant service, NHG Eye Institute, Singapore, said that toric IOLs account for 20 to 40% of the premium IOL market. That probably also reflects the proportional needs for astigmatism correction in the entire Singaporean population.

Dr. Fam often implants the AcrySof Toric IOL (Alcon, Fort Worth, Texas) in patients.

Dr. Fam currently uses toric IOL models that correct lower amounts of astigmatism, anywhere from 1 to 2 D. The needs are far greater than that, however. "Some patient with very high amounts of astigmatism cannot be fully corrected with current toric lenses," Dr. Fam said. "Post-operatively, they still have some residual astigmatism."

Dr. Fam is looking forward to correcting anywhere from 2.5 to 4.5 D of astigmatism, which he expects he'll be able

to do soon with AcrySof lenses in Singapore. "Hopefully we can do more justice for these patients soon," Dr. Fam said.

Visual justice needs a strong education foundation, however. That's why **Jodhbir Mehta, M.D., FRCS**, Consultant, Cornea, External Disease and Refractive Surgery, Singapore National Eye Centre, Singapore, is a fan of Singapore's eye education days, which are free to the public. These public hospital forums are advertised in national newspapers.

"People can come in and listen to talks in Mandarin and English," Dr. Mehta said. "These talks are all about cataracts, cataract surgery, and the different IOLs available."

Patients also are examined for cataracts, glaucoma, and diabetic changes. Basic refraction and dilated examinations are performed by ophthalmologists. Problems are addressed appropriately with referrals.

At the individual clinic

level, Dr. Theng said he's "probably the main factor in explaining everything," although his center also provides brochure and DVD explanations. Surgeons still need to do more, though, he said.

"Not enough surgeons are using the toric lens for patients to determine the obvious need of the lens," Dr. Theng said. "Also, based on recent meeting experiences, a lot of new doctors are being told of the benefits of the toric lenses. They have an aversion to using

the lens because of a notion that it could be a lot tougher to implant, when actually it's quite easy."

Surgeons also shouldn't forget the pearls of developing a healthy multifocal lens-based practice. Although many people already present with an understanding of multifocality and a desire for it, expectations must be set during counseling, Dr. Wavikar said. "If cylinder is more than 1 D, I don't implant a multifocal," Dr. Wavikar said.

Multifocals, nonetheless, form an important part of the refractive lens exchange surgeon's armamentarium. There's simply no difference here between Asia and the West. "Everybody gets presbyopia," Dr. Theng said.

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“[New doctors] have an aversion to using the lens because of a notion that it could be a lot tougher to implant, when actually it's quite easy”

Surgeons highlight benefits of toric IOLs

Liminal relaxing incisions (LRIs) are starting to look a little dated. That's according to various Asian surgeons, who are more frequently opting to implant toric IOLs, which they say do a better, more predictable job of astigmatism correction than LRIs in many cases.

"LRIs have a limited range of correction, and they are not very accurate," said **C.M. Wavikar, DOMS**. There are also elements of regression, as well as quality of vision issues pertaining to glare, he said.

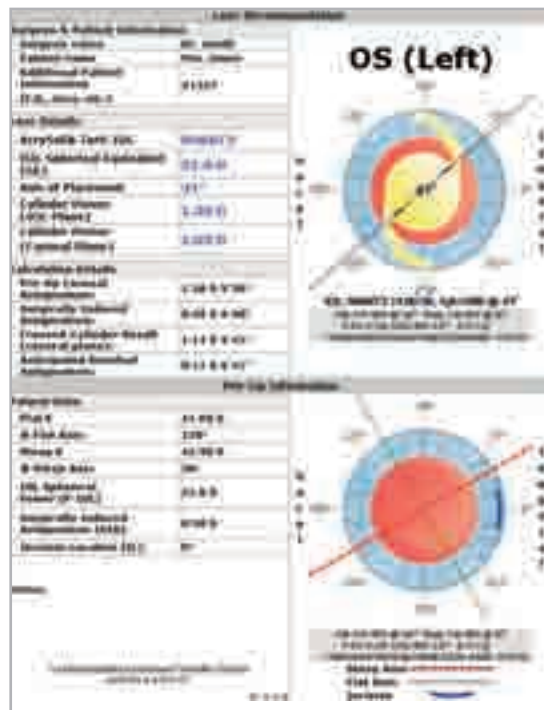
Instead, Dr. Wavikar opts to use the AcrySof Toric IOL (Alcon, Fort Worth, Texas) for astigmatism correction. "Basically, the toric IOL delivers whatever we promise to the patient," Dr. Wavikar said. "So if the patient is a perfectionist, I would rather go for the toric IOL."

Currently, Dr. Wavikar is working on a study of Indian eyes in 30 patients, attempting to measure rotation of the AcrySof Toric IOLs. Rotation potentially is a problem because it could nullify the astigmatism-correcting virtues of toric IOLs.

"Previous models of toric IOLs rotated quite a bit," Dr. Wavikar said. "In this model, however, there is hardly any rotation of the lens."

There are two main qualities that make the AcrySof Toric IOL successful, Dr. Wavikar said. First is rotational stability. The second is the exquisite toric IOL calculation software, he said.

Dr. Wavikar suggested that to attain good toric IOL placement, be accurate in measuring pre-op cylinder. Also, he recommends performing the same precise surgery on every patient. "If we do this, we are on target almost 100% of the time," Dr. Wavikar said.



The AcrySof Toric Calculator can help surgeons determine which lens to use

Julian Theng, MBBS, FRCS, FRCOphth, Medical Director, Eagle Eye Center, Mount Alvernia Hospital, Singapore, agreed that rotational stability of the AcrySof Toric lens is superb.

"I have no qualms offering 1.5 D astigmatism patients the AcrySof Toric IOL," Dr. Theng said. "It is much less likely to rotate in the eye than any other design. It's very stable."

Although Dr. Theng still offers LRIs to patients with less than 1.5 D of astigmatism, he says the AcrySof Toric IOL is a breakthrough at the 1.5 D threshold.

"It provides clear-cut benefits that the LRIs can't match," Dr. Theng said.

LRIs also take time to implement satisfactorily in clinic, according to **V.C. Mehta, M.S.**, Mehta Eye Clinic, Mumbai, India. "For the LRIs, you need to develop a nomogram," Dr. V.C. Mehta said. "You

need some cases before you can predictably achieve correction of astigmatism."

He also cited LRI problems of regression and the limited range of astigmatism correction.

As much as Dr. V.C. Mehta is not an LRI fan, he is an advocate of the AcrySof Toric IOL. "If you have 10 to 15% of your patients with preexisting corneal

astigmatism and you make them happier [with the AcrySof Toric IOL] than they would have been with a normal aspheric lens, this impacts the remaining patients, too," Dr. V.C. Mehta said.

In other words, attach importance to your patient minorities, like ones with astigmatism; once they achieve good uncorrected vision, they will happily refer other patients to your practice.

Dr. V.C. Mehta also suggested that because of the superb lens material, the AcrySof Toric IOL will remain in place for the rest of the patient's life, carrying the astigmatism-correcting effect with it.

LRIs have their niche uses, Dr. Theng said. When implanting multifocal IOLs such as the AcrySof ReSTOR +3.0 D IOL in patients with some degree of astigmatism, LRIs are a good option, he said.

Jodhbir Mehta, M.D., FRCS, Consultant, Cornea, External Disease and Refractive Surgery, Singapore National Eye Centre, Singapore, said he even uses the standard AcrySof Toric IOL in patients with just a single diopter of astigmatism or more. "I normally use the toric lens if the cylinder is greater than 1 D," Dr. Mehta said.

Although some surgeons may be worried about visual degradation with axis shift, Dr. Mehta said he has found a way to minimize this.

"We did a study in the U.K. a couple of years ago when a lot of doctors were advocating on-axis incisions," Dr. Mehta said. "We looked at the effect of on-axis compared to temporal incisions. Even though doctors thought they were reducing astigmatism by staying on axis, you also get a bigger variation in axis shift on-axis as compared to with temporal incisions. Now I do all my surgeries with temporal incisions."

Han-Bor Fam, M.D., Senior Consultant and Head of The Cataract and Implant Service, NHG Eye Institute, Singapore, currently uses the standard AcrySof Toric IOL and looks forward to when higher diopter ranges are introduced into his market, which should occur shortly.

"We are hoping we can expand the astigmatism-correcting range of these patients, which previously could not be corrected," Dr. Fam said.

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